THE
COMMUNITY HEALTH CENTRE
IN CANADA

REPORT OF THE

COMMUNITY HEALTH CENTRE PROJECT

TO THE

CONFERENCE OF HEALTH MINISTERS

NATIONAL HEALTH GRANT

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COMMUNITY HEALTH CENTRE PROJECT / ÉTUDE SUR LES CENTRES LOCAUX DE SANTÉ

July 21, 1972.

The Honourable John Munro, P.C., M.P.,
Minister of National Health & Welfare,
Ottawa, Ontario.

Dear Sir:

CONFIDENTIAL

We submit to you, in your capacity as chairman of the Conference of Health Ministers, our Report, unanimously approved, on Community Health Centres in Canada.

Respectfully,

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John Barker, Sault Ste. Marie
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ACKNOWLEDGEMENT

Acknowledgement of commissioned studies and papers, of written submissions, of special seminar participation, and of those visited and consulted is made in the Appendices. I wish, however, to add a special word of appreciation to my colleagues on the Project Committee. They brought a rich diversity of views and experience to the task and worked diligently in weighing the many issues we faced. Their dedication and collective wisdom have made a unanimous Report possible. I would also express my indebtedness to my colleagues of the Project staff. They have been a perceptive, cheerful and hard-working team. The quality of the Report and its completion on time are in no small degree the result of their commitment and loyalty.

I would like also to acknowledge the many kindnesses and the unfailing support given the Project by the federal Department of National Health and Welfare, in particular by the Assistant Deputy-Minister of the Health Programs Branch and his staff. To my colleagues at the School of Hygiene, University of Toronto, who carried extra teaching and research responsibilities in my absence, goes a special word of thanks. Beyond these specific acknowledgements, I can only express a general but genuine word of appreciation to the many people in governments, the federal and provincial civil services, professional organizations, a wide range of citizen organizations, the universities, and the general public who have helped in one way or another. The experience of the Project has given me a deeper understanding of Canada in all its rich variety and of that greatest resource of all -- our people. Finally, to my wife and family I give special thanks for their understanding and support during a busy, hectic, but always challenging, exciting year.

John E.F. Hastings,
Chairman, Community Health Centre Project Committee
& Project Director.

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Note: The opinions and conclusions expressed in these special appendices are those of the respective authors only and do not necessarily represent the views of the Committee. They are included for information and reference purposes.

PRINCIPAL RECOMMENDATIONS

1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres, as described in this Report, as non-profit corporate bodies in a fully integrated health services system.

2. The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.

3. The immediate initiation by provincial governments of dialogue with the health professions and new and existing health services bodies to plan, budget, implement, co-ordinate and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding, and country-wide evaluation.

Note

(a) Other recommendations are found on pp. 28-29, 47-48.

(b) Statements in the text which the Committee wishes to emphasize are printed in heavier type.

FOREWORD

The Community Health Centre Project was set up by the Minister of National Health and Welfare on behalf of the Conference of Health Ministers of Canada for three reasons:

1. A growing concern of both federal and provincial governments about the accelerating rate of spending in health services. During the 1955-68 period the average rate of annual increase in the cost of providing all health services in Canada was approximately 10.7 per cent. In 1968, government sources accounted for 69 per cent of combined operating and capital spending in health services in Canada. Spending from all sources in the same year represented some 6.6 per cent of the gross national product. In the last three years, the rate of increase was running well above the 10 per cent average and for 1971 the indicated rate of increase in spending is about 12.5 per cent. The rate of increase in the expenditure on acute hospital care has been around 14 per cent and shows no sign of slowing.

2. A growing belief that some shift from the present emphasis on acute hospital in-patient care to other forms of health care, including types of community health centre, offer a means of slowing the rate of increase in health services spending. This idea has arisen in part from a few recent Canadian reports on the Saskatchewan community clinics and on two Ontario group health centre programs. These reports have indicated that such programs can achieve important reductions in hospital in-patient bed use. This finding is similar to American reports on the experience of the various group practice prepayment programs and on the experience of the Office for Economic Opportunity health centres in that country. The current proposals for Health Maintenance Organizations in the United States are also in part based on potential savings which it is hoped will result from a reduction in in-patient hospital use.

3. A growing belief that community health centres, variously defined, offer an effective response to many problems other than costs in the existing ways health services are provided. It is suggested that they offer a setting in which the community's resources can be brought to bear in a more dynamic relationship with the health professionals and services in trying to solve people's health and related problems. This newly aroused interest in "people-centred" and "problem-centred" approaches to health care has arisen among other sources from the Castonguay-Nepveu (1) and Celdic Reports (2) in Canada, the American O.E.O. and H.M.O. experience, current developments in the United Kingdom and elsewhere, as well as from a general awareness that better ways are needed for meeting the many-sided problems people, families and communities now face and will be facing in the future.

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(1) Commission of Enquiry on Health and Social Welfare, Quebec, 1970.

(2) Commission on Emotional & Learning Disorders in Children, Toronto, 1970.

In summary, community health centres are increasingly seen as an important means for slowing the rate of increase in the cost of health services and for more fully reflecting the objectives, priorities, and relationships which society wishes to establish for health care in the future.

The Committee's task was to examine available evidence, to seek opinions, to consider proposals, and then to make specific recommendations on the provision of health services through community health centres and the possible role which governments and others might play in encouraging their development. We have done our best to fulfil our mandate. The choice is now for Society to make - in other words for each of us as responsible Canadian citizens.

THE COMMUNITY HEALTH CENTRE - WHAT IS IT?

The Committee sees a community health centre as a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality. Such care must be provided in an acceptable manner through a team of health professionals and other personnel working in an accessible and well-managed setting. The community health centre must form part of a responsive and accountable health services system. In turn, the health services must be closely and effectively co-ordinated with the social and related services to help individuals, families, and communities deal with the many-sided problems of living.

What does this mean?

"a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality..."

A community health centre is an organization and service concept, a financial and administrative integration of resources to help people to deal humanely and rationally with one another in receiving and providing health services. It recognizes and gives form to the dynamic interaction necessary between the helper and the helped. It promotes personal and community responsibility.

The emphasis must be on high quality initial and continuing care for meeting the health needs of individuals and families. There must be a balance in services among health promotion and prevention, diagnosis and treatment, and rehabilitation. There must also be provision for dealing with urgent problems. All services must meet accepted, current, and system-wide standards of quality.

Health promotion and prevention includes counselling to prepare people for the various phases of life, education to improve living habits, family planning, and specific protective measures, such as immunization. Diagnosis and treatment includes reception and direction to the appropriate service within the centre, history-taking (including record retrieval and up-dating), initial diagnosis, decision on specific therapy, follow-up, and continuing supervision of care. Rehabilitation includes medical and social restorative measures within the competence of the centre and/or referral to more specialized services.

No organized setting can by itself assure high quality service. But there are measures that support quality which can more readily be taken in organized settings, such as the community health centre. These include peer review, records review, accreditation and audit measures, encouragement of clinical and organizational research and continuing education (both extra-mural and in-service). The involvement of the public in advisory and monitoring capacities can be helpful in assuring other facets of quality (1) such as responsiveness and acceptability.

"...in an acceptable manner..."

Provision of health services of high quality is not enough. Services are for people and must be given in an atmosphere and in ways which people understand and accept. Care must be taken not only to assure acceptability by the majority of people but also to assure that services for particular groups, such as the young, the aged, the poor, and people of different cultural backgrounds, are offered in imaginative and problem-centred ways.

In turn, services are provided by people -- health professionals, other professionals, technologists, auxiliaries, and support personnel of many different types. They, too, have expectations and needs which must be recognized. The manner in which their skills and services are used will in large part determine not only their feelings of responsible involvement and work satisfaction but also the atmosphere of the community health centre and the quality of care which it provides.

In short, the community health centre can only be effective if it is a mutually acceptable partnership of the members of the community and the members of the health care team.

"...through a team of health professionals and other personnel..."

Central to the concept of a community health centre is the provision of care through an integrated team of various types of health professional, other professionals, technologists, and other personnel working together to try to solve people's problems. Each member of the team should be encouraged to use his training and skills to the best of his ability and in mutual support of his colleagues.(2) The particular functions of team

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(1) See also p. 2 *("in an acceptable manner")*, p. 7 ff *("part of a responsive and accountable health services system")* and pp. 41-43.

(2) It should be noted that not all of the skills required are those of health care professionals and technologists, as for example, telephone crisis centres and other forms of "lay" involvement have shown.

members, even the team's precise composition, should vary in response to the specific needs of the person and community being served. This requires a careful matching of skills to problems so that no skills are over or under used. Only through such teamwork can a safe transfer of tasks be achieved and high quality care be assured.

For providing the **basic medical services** the minimum service unit should consist of personnel whose combined skills are those usually now found in the general or family physician, the public health nurse, and registered clinical nurse.(1) In isolated areas, skilled nurses have for some years been serving as *de facto* nurse practitioners who, to a large extent, have substituted for the physician. The addition of a formally prepared nurse practitioner-midwife or her substitution for the physician in special circumstances is a logical means of giving acceptable quality care, provided workable communications and supervision arrangements exist.

The **basic dental service unit** should consist of personnel whose combined skills are those usually now found in the dentist, dental hygienist, and chairside assistant. (2) The addition of a qualified dental nurse practitioner or an expanded-role (3) dental hygienist or even their substitution for the dentist in special circumstances is a proven means of giving preventive care. If workable communications and proper supervision exist, such a substitution has been demonstrated as a way to give basic dental treatment of acceptable quality.

Although such basic service units can function effectively in providing medical and/or dental care, they do not in themselves have all of the attributes of a full community health centre team as envisioned by the Committee. First, the active and responsible involvement of people in their own health care and the care of others is essential to our concept.

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(1) Precise population/service unit ratios are, at best, an informed judgment on work productivity but the type of minimum service unit outlined could serve between 1800 to 3000 people depending upon such factors as geography, accessibility and age structure and other special population characteristics, e.g. any characteristics which might require an above average psychosocial emphasis in a practice, usually more time consuming.

(2) In our view such a service unit could serve some 2000 to 3500 people, again depending upon such factors as geography, accessibility, age structure, emphasis on health education, etc.

(3) As for example, in New Zealand, the United Kingdom and the Canadian north with dental nurses. A course for dental nurses, who will carry out some therapeutic procedures as well as preventive procedures under supervision, is being started in Saskatchewan in the autumn of 1972.

Second, for inter-collegial relationships and task sharing to be fully possible and for other basic personnel, such as the social worker and laboratory technologist to be economically and efficiently included as team members, a grouping of three or more medical and two or more dental units (1) is necessary.(2) Only when these two criteria are met can the service group be regarded in our view as a community health centre team.

As the number of service units in a community health centre is increased, other types of basic professional and technological personnel, such as the pharmacist, optometrist, and x-ray technologist may be economically and efficiently added to the team. More specialized medical personnel, such as the paediatrician, obstetrician-gynaecologist, internist, psychiatrist, general surgeon, orthopaedic surgeon, radiologist, and pathologist, as well as personnel such as the physiotherapist, health educator, community nutritionist, clinical psychologist, denturist, and podiatrist, may be usefully added.(3) Such larger and more varied community health centre teams permit greater specialization and some reallocation of tasks among the team members. The types and numbers of personnel added to the basic team of any specific community health centre should take account of factors such as the size and particular health needs of the population being served, and the distance and ease of access to specialized services based in referral hospitals.

The Committee feels that there is an upper limit in size for a single health team in a community health centre. Experience with existing medical group practices and community clinics suggests that, in terms of effective internal communication, colleague interaction and organizational efficiencies,(4) the upper limit for the number of physicians is around a dozen if the physicians are all family physicians. If specialist medical personnel are included then this upper limit appears

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(1) In the absence of dental services, the centre would be a community medical care centre.

(2) This postulates a base population for a basic community health centre of some 6,000 to 9,000 people, again depending upon specific circumstances.

(3) The future role of other groups such as osteopaths and chiropractors, in the health services system is currently under review in several provinces. We would only note that if they are to be included it should be in the supervised team setting of the community health centre, so that their services may be used in an integrated fashion with other team members.

(4) Ruderman, p. 2.

to be around 20 physicians. The number of other types of team member would be varied accordingly. Dental groups are rare in Canada but, in terms of personal interaction and economies of scale, a figure similar to that for family physicians seems appropriate. Depending upon the population density in the area served, a community health centre could, of course, consist of more than one health team. Such multi-team community health centres could add less common specialized personnel. In other words, the actual composition of staff and the number and types of team in any community health centre must change in response to the particular situation.

For special diagnosis and care, single specialty medical groups, and large multi-specialty specialist medical groups, as they now exist, and large hospitals would serve as referral and consultancy resources for several community health centres. Multi-specialty medical referral groups and larger hospitals could also have one or more community health centre teams integrally related to them for providing basic health care to the people in their immediate area. The university health sciences centres and the highly specialized services they offer should be outside the regular system in the sense that they should be ultimate referral, consultancy and back-up resource centres for the entire system.(1)

People using a centre's services should recognize the team concept of health care and be encouraged to establish a relationship with an appropriate member of the health team. In times of emergency, outside regular hours, or on a long-term basis, only a team, relying on an effective records system can assure continuing and competent care.

While the community health centre has been defined in terms of medical and related health services and the team approach, several provinces are extending or planning to extend the concept to include social services. In Quebec, for example, the centre is called a local community service centre (C.L.S.C.) and, in Manitoba, a community health and social development centre. This combination of health and social services reflects a growing recognition of the intimate relationship between these two services fields. In such situations, the basic social service unit should provide, co-ordinate and integrate individual and family counselling and supportive services for families, such as day care and homemaker services. The basic social service unit should play a dynamic and key role in community education, organization, and development.

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(1) See discussion of referral systems p. 39.

"...working in an accessible setting..."

The population to be served by a community health centre must have ready access to its services. The location of a particular centre and whether or not it is a single facility or also has sub-centres (1) and/or mobile units linked with it would depend upon the time needed to reach the centre by the common means of transport physically and economically available. In all situations, for people unable to travel easily, whether for reasons of illness, cost, distance, or weather, the health services system should have arrangements for ensuring either that the people can get to the services or the services to the people.

Two related questions are whether a community health centre should provide regular 24 hour service and whether it should offer services to handle other than minor emergencies. Both types of service should be reasonably available within any given area or district. But their precise location will depend on local circumstances, such as one or more hospitals in an area providing 24 hour emergency and other coverage. This may suffice in some communities whereas in others factors of geography or size of population may necessitate some or all of the area community health centres offering regular care and/or full emergency services on a 24 hour basis. In all cases, an efficient communication and records exchange system within the health services system in an area is essential.

Finally, the question arises whether a community health centre should include beds of some type. It is the Committee's firm opinion that a community health centre is not and should not be allowed to become a *de facto* small hospital, since one goal in developing community health centres is to reduce the present level and dependence on in-patient acute hospital bed care. On the other hand, especially in situations remote from a hospital and under certain difficult geographic and climatic conditions, a very few short term emergency holding beds would be necessary. It should be emphasized that such holding beds are only for use until transfer to an appropriate hospital setting can be effected.

"...well managed setting..."

Efficient techniques of management must be employed both to support the professional operation of the health services team and to ensure courteous and prompt care for the public. A professional administrator is necessary for good relations with the public, linkage with the health services administration, and handling problems of case management. He

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(1) In which one or more basic service units but not a full community health centre team would be located.

must assure the records and communication system is used for purposes of audit, evaluation, and referral. Educational programs must train management personnel for the health services system and for its component elements, such as community health centres.(1)

"...part of a responsive and accountable health services system..."

The community health centre and the health services system of which it is a part must be responsive to the health needs of people. Health needs are of two types. First, there are needs as determined by epidemiological methods. Continuous evaluation of health services is necessary if there is to be awareness of the changes in health indices and the ways in which scientific developments can be applied in responding to them. An integrated system and the team approach of the community health centre provide a setting for monitoring change, communicating new knowledge and methods, and evaluating the results of services.

Second, there are the felt needs of individuals, families and society. Such needs vary from person to person and from group to group. So, also, must the ways in which responsiveness to perceived needs is assured.

Responsiveness may be further assured by people actively involving themselves in programs of health promotion and health maintenance, assuming a wider responsibility for their own health and that of their families, and using services in an as intelligent and effective way as possible. Responsiveness may be promoted by involving the community in policy-making, priority-setting and decision-making through various forms of boards, councils, and advisory or grievance bodies. It may be helped by the use of "lay" health workers or "members relations" personnel serving as intermediaries between the public and the health services; in other words, by assuring effective "two-way" communication.

Responsiveness does not require or even desirably mean the same kind of individual and community involvement in each and every situation. For example, a community which has experienced poverty and neglect or which has different cultural values will require means for relating to community health centres different from other segments of the population.

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(1) There are presently courses for public health personnel, hospital administrators, and other health administrators at both the basic and advanced level in the universityand on an extra-mural basis through the Canadian Hospital Association. But these existing courses require adaptation to assure curriculum relevance in the changing period ahead.

Our concept of a community health centre as part of an integrated health services system is a flexible one which responds to the felt needs of people and which may be adapted to the circumstances of each particular situation. Whether community health centres need a distinct policy board is in our view a factor of the size and complexity of the centre.(1)

In every case, the community health centre should be an integral part of a wider health services system which is responsible and accountable to the public interest. Only in this system setting will its full economic and service potential be achievable. It must not simply be an additional independent functioning component in an already fragmented services pattern.

The concept of the health services system is discussed later in the Report.(2)

"...closely and effectively co-ordinated with the social and related services to help people, families, and communities deal with the many-sided problems of living..."

It has been recognized for some time that many health problems have a psycho-social and economic component and that many psycho-social and economic problems have a health component. Thus, health care programs often include consultant and supportive social work services and social welfare programs often include supportive and consultant medical services. But in both instances, one purpose or function is clearly dominant.

Now, however, it has become clear that more and more of the problems which affect individuals and families cannot be neatly classified as health, social, economic, legal, education, employment, or housing problems. Among examples of this sort of personal and societal "disease" are mental illness, drug and alcohol dependency, delinquency, alienation between parents and children, personal violence and violence against society's established institutions, and many problems of the aged. Because the number and nature of such problems will undoubtedly increase in the future, community health centres must have practical working relationships with social services and with other community resources. As in the case of citizen involvement, community needs differ and, therefore, community service patterns will vary. For many communities, a well-developed records system and communication between services may suffice for achieving effective joint action. Cross-appointments at the planning, administrative and service levels would facilitate the development of a referral network.

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(1) For further discussion see p. 42.

(2) Pp. 30-45.

However, as noted, some provinces additionally propose a fuller integration of health services with other personal services at the community and/or provincial levels. Quebec and Manitoba, for example, are implementing integrated health and social services at all jurisdictional levels and proposing a "single unit" and/or "social unit" for providing community services. Although not all members of the Committee are agreed on the immediate need and practicality of a fully integrated personal services system, we all agree that there are circumstances in which it is the only effective approach. In a smaller community, for example, there are reasons (financial, administrative, geographic) for establishing integrated units to provide all personal and family support services. These combined units may also be an effective means for helping communities whose people find it difficult to deal with a variety of service agencies. In the long run, the combined unit may prove to be the most effective means of meeting the needs of all communities. Such developments should be supported, encouraged, and evaluated.

In summary,

The central concept of the community health centre is teamwork. The kind of team work which is meant is not the kind of teamwork which has been developed in hospital operating theatres, a para-military system to deal with the inert patients, but the milieu therapy approach, developed first in mental hospitals, and later in community psychiatry. This approach recognizes that all those who have contact with the client may influence his behaviour and his self-concepts, but that professionals have a special responsibility in making their interventions not only to help the patient but to help others to help him, and to help him to help himself. The focus is not upon the physician as team leader but upon problem-solving processes for the client/patient. Naturally, the physician is better equipped to treat organic [i.e. medical] problems, but other members of the team may have more useful contributions to make to psychosocial or social difficulties, and this approach focuses upon helping the patient to take greater responsibility for his own health and the community to take greater responsibility for its members.(1)

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(1) Crichton, p.

THE COMMUNITY HEALTH CENTRE - WHY?

ECONOMIC REASONS

Studies for the 1969 Task Force Reports on the Cost of Health Services in Canada, based on projections of economic growth and allowing for an annual rate of increase in health services costs of 10 per cent (a marked reduction in the current annual rate of increase) arrived at a predicted level of spending of 7.4 per cent of the gross national product for health services in Canada by 1981.(1) Government expenditure is predicted as accounting for 92 per cent of all health spending by that year. The Economic Council of Canada in its 1969 Report went so far as to predict that spending on health and education in Canada was accelerating in a manner which, if unchecked, could lead to the full use of the gross national product for these purposes by the end of the century. Although the precise figures and the precise manner of their derivation are open to some differences of interpretation by economists and other finance experts, there is no questioning of the facts that the rate of spending in health services is now increasing at an annual rate which, if unaltered, will either result in the use, in the near future, of a greater proportion of Canada's gross national product for these purposes than at present or in limitations on existing essential services. The real question is, therefore, not how much we will be spending but what we will be getting for the money.

How may community health centres help in achieving the potential economies of a health services system?

REDUCING HOSPITAL IN-PATIENT USE

It is generally accepted that the greatest potential for economies in the use of health care resources lies in reducing expenditures in the largest and most rapidly growing area of spending within the health services -- the hospital, especially the acute general hospital. We recognize that reductions in hospital costs may be achieved (and are now being realized by many hospitals) through increased efficiency in the operation of the hospital itself. Emphasis on earlier discharge, day care surgery, progressive patient care, careful planning of admissions so that they are more closely timed for the carrying out of specific procedures, sharing physical support services with other hospitals, and the increasing emphasis on modern managerial and administrative methods are all steps toward greater economy. However, their impact is presently limited by the economic disadvantages under present funding arrangements of the hospital being "too efficient" (i.e. in having too many beds not in use at any given time), by the absence of sufficient alternative care services and facilities in the community, and by the absence of an effective communications and referral system among the existing community services and facilities.

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(1) Task Force Reports on the Cost of Health Services in Canada, Committee on the Costs of Health Services, Ottawa, 1969, Vol,3, p. 431ff.

But the chief means of controlling costs within the hospital sector is to be found in a reduction in the present acute bed/population ratio and a consequent reduction of in-patient services and facilities. Increased emphasis on alternative forms of care, such as extended care facilities, home care programs and community health centres, are seen as ways for achieving this goal. However, it must be emphasized that any real savings from a reduction in hospital in-patient utilization can only result if alternative forms of care not only replace some proportion of care presently provided on an in-patient basis but also if there is a co-incident reduction in available in-patient facilities.(1) Unless both steps (substitution and reduction) are planned and taken together, experience has shown that freed in-patient beds are almost always filled by new patients.(2)

It should also be noted in passing that staff and plant requirements are not reducible in direct relation to a reduction in beds. Certain basic levels have to be maintained in respect to quality and the ability to meet changes in work load.

It should be stated here and borne in mind in other sections of the Report that one of our basic problems in gathering and assessing evidence was that examples of the full concept of a community health centre as proposed in this Report do not presently exist. We must, of course, hasten to add that a wide variety of existing and proposed forms of practice and services in Canada and elsewhere have many of the attributes (in different combinations and to varying extents) of our concept. Our conclusions, therefore, had to be based on inferences from the existing available data.

There is some evidence that there is a lower in-patient hospital utilization rate among group medical practices compared with solo medical practices in similar fields of work. However, the magnitude of the reduction varies with such factors as size of group, type of physician composition of the group, field of work, locality and province.(3)

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(1) Overall hospital costs would be reduced but it should be noted that removal of "lower cost cases", who could be cared for under out-patient forms of care, would result in a higher per diem patient cost since the more serious and acute cases requiring intensive use of staff and facilities would remain.

(2) It is not directly germane to the argument that some of this new bed use in certain communities may represent previously unmet need.

(3) Ruderman, p. 1, pp.16-34, pp.38-41.

There is stronger evidence from the small number of existing Canadian cases that, with proper incentives and management, community clinics and group health programs do result in lower hospitalization rates than do either solo medical practices or physician-sponsored medical group practices in generally similar situations.(1) The reduction in hospital utilization is mainly a function of lower admission and readmission rates rather than shorter lengths of stay once a patient is admitted. Substantially lower surgery rates and possibly the increased use of out-patient laboratory and x-ray diagnostic procedures are also factors.(2) The resultant savings from reduced hospitalization should more than offset higher initial costs of out-patient care in the group health clinics. (3)

It is difficult to determine the extent to which the cost-savings shown in the studies of the community clinics and group health associations arise primarily from factors of internal organization or from other variables such as public involvement and motivation, professional ideologies and treatment theories, and the existence of alternative facilities. Thus, we cannot predict the extent to which the cost savings achieved in these settings is capable of generalization. Reduced hospitalization (and the consequent savings) will definitely occur to the extent that community health centres and other low cost alternative forms of out-patient service replace in-patient general hospital services within the health system.

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(1) Ruderman, p.2, pp.27-34, p.43. Se also Hastings, John E.F., Mott, F.D., Hewitt, D., and Barclay, A. "An interim report on the Sault Ste, Marie Study": C.J.P.H. 61: 289, 1970, and Anderson, D.O., "What price group practice?" (in course of publication), and Crichton, Anne, "The organization of group practice in Saskatchewan, 1967-70," (in course of publication). American experience with group practice pre-payment programs shows definitely reduced hospitalization rates but differences in funding and other circumstances make difficult reliable inference from these situations to the Canadian context of universal government hospital and medical insurance.

(2) Hastings, J.E.F., and others, "Prepaid group practice in Sault Ste. Marie, Ontario, Part I: Analysis of utilization records." (in publication, Medical Care.) A problem in assessing the impact of greater out-patient diagnostic work-up is that procedures carried out by laboratories and radiological facilities other than those of the admitting hospital are frequently regarded as having to be repeated by the hospital after admission.

(3) There are indications that hospital savings are more difficult to achieve under universal medical care insurance. This doubtless indicates that the usual medicare payment methods contain disincentives to reduction in hospital use. To ensure hospital savings occur, management of the centre must be able to direct policies of the centre towards that end.

INCREASING PRODUCTIVITY AND EFFECTIVENESS

Experience within a wide variety of health service programs in Canada, including the *de facto* "nurse practitioner" in the north or in the Newfoundland and Labrador nursing outposts, the experience of an integrated private dental group practice, (1) various experiments and demonstrations of substitution of public health nurses for doctors in private practice, the use of optometrists in community clinic-group health settings for refraction work, the experience of pharmacists in hospital pharmacy and community clinic-group health settings, the use of selected critical screening procedures carried out by non-physician personnel in community clinic-group health settings, the use of health aides or intermediaries in special communities (Indians, Eskimos, urban core communities, etc.), and the extensive hospital experience with special surgical teams and intensive care units, show that:

1. In organized and supervised settings, a team of various types of personnel, each member of which carries out specific functions, definitely increases the efficiency and productivity of the physician, dentist,(2) and other professional personnel as compared to situations of solo and largely unsupported forms of practice.

2. It is also definitely possible to substitute less highly trained professional and technological personnel for more skilled personnel in organized and supervised settings, such as hospitals, health centres, and group practices, without any danger to public safety or diminution in quality of health care. This is also true in situations where only limited supervision is possible, such as the north, provided back-up and referral services are reasonably available.

However, it must be pointed out that team-work and/or substitution (devolvement of functions) while leading to greater efficiency in the use of resources do not automatically produce cost savings. They may in fact bring about greater costs because they allow (and may cause) a greater volume of work to be done. Savings result when there is a real reduction in the numbers of more skilled and expensive personnel used for the same volume of work.(3)

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(1) Data from the Assiniboine Clinic in Winnipeg showed greater productivity and significantly reduced unit costs.

(2) P. 13, footnote 1.

(3) As noted elsewhere, there would in many circumstances be a shift of some of the costs to the individual and family. Attention must be given to assuring that such new costs are included in any cost comparison.

The concept of community health centre we have outlined offers one setting in which the efficiencies of team work and substitution of personnel can be actively encouraged and achieved. Whether actual reductions in expenditure will result is another question which is chiefly related to disease incidence, willingness to delegate by physicians, dentists and other professionals (1) and receptiveness to the team approach among the health centre population. Present funding arrangements and legislation as well as regulatory provisions would have to be modified, as noted elsewhere, for the full benefits of team work to be achieved.(2) A health services system which includes community health centres would make these changes easier to effect.

ACHIEVING OTHER ECONOMIES

Experience in Canada and elsewhere in hospitals, group health-community clinic and many group practice settings has demonstrated that better cost/benefit ratios are possible through the employment of professional managerial and administrative personnel, modern records and communications methods, bulk drug purchasing of suitably prepackaged unit amounts and the development of unofficial and regularly updated formularies, and the fuller use of special facilities (laboratories, x-ray, rehabilitation, pharmacy (3)). Community health centres make possible the use of these measures but their full economic benefit can only be gained within a health services system which allows their effect to spread beyond a single situation.

SOCIAL, POLITICAL AND ORGANIZATIONAL REASONS

One of the main reasons for establishing the Community Health Centre Project was a feeling that *"better health care is not coming out of an [increasingly] expensive medical care system and that medical care delivery could be better organized. It is the system rather than the individuals in it which is at fault."(4)*

Might community health centres provide answers to some of the social, political, and organizational questions and issues which are concerning the public, the health professionals and governments?

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(1) Crichton, p.

(2) pp. 19-22, 33.

(3) Legal changes in provincial Pharmacy Acts are necessary in most jurisdictions.

(4) Crichton, p.

ATTITUDES AND CONCERNS OF THE PUBLIC

The concerns of the public about health services are difficult to pin down.(1) This is undoubtedly due to the fact that most people rarely think about health services except in times of need. When people do express concern, their remarks tend to be about the organizational rather than the clinical aspects of health care. They want care provided promptly and in ways which they understand and accept. When they move to another town or province, they want to be able to establish a relationship with a physician quickly and easily. They want easy access to on-going treatment for the special problems they or their families may have. They are more concerned with the particular way they are cared for than they are with any general measurement of "health outcomes".

In other words, although they do not use the "jargon", the public are concerned about availability, accessibility, acceptability, continuity, and the process of care.

Many of these concerns reflect problems in the existing health services pattern. Present services do not take sufficient account of the special needs of many groups (the aged, the youth, the Indians, the poor). Access to services often seems to be concealed in complex bureaucratic procedures that confuse people of all socio-economic groups. Mounting pressures on out-patient and emergency departments indicate, in part, a lack of alternative services. Procedures and treatments are often not clearly explained and little attention is paid to evaluating individual satisfaction during an episode of care.

We have already described in considerable detail the way community health centres can assure acceptable services, provide on-going care, and cope with individual concerns. They can also become easily identifiable and accessible points where appropriate decisions can be taken about solving people's health care problems. They can offer a balanced service program and relate, as necessary, to other health care services and community social services on a co-ordinated and integrated basis. They provide the opportunity to involve individuals more fully in decisions about service provision as well as in personal and family health care.

The changing of public expectations is a more difficult matter.

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(1) Attempts were made by the Project to determine public feeling through solicited citizens' organization submissions, newspaper advertisements (country-wide), letters to Members of Parliament and Senators and personal interviews.

The Committee believes that community health centres can and should provide a setting for formal(1) and informal education necessary to change attitudes. The public should understand that modern scientific medicine is limited in what it can accomplish -- many ills cannot be remedied. Individuals must take real responsibility for personal and family health (diet, smoking). They should be made to feel confident that nurses and other non-physician personnel can give high-quality care and that community health centres can provide many services as effectively and safely as hospitals.

Finally they must understand that any demand for "more" or "better" health care has a price -- both economic and social.

ATTITUDES AND CONCERNS OF HEALTH PROFESSIONALS

We have been forcibly struck by the feeling, frequently strongly expressed, of many professionals and technological groups that their skills are presently not being used to full effect in the care and treatment of individuals and families. They point out that in a field which is as complex and specialized as health care, no one person can have undetstanding and competence in all areas. These groups of professionals, particularly the nurses, also made clear their unwillingness to continue accepting the dominance of the physician in providing health care. They see themselves as possessing a depth of knowledge and skill in their particular area that surpasses the knowledge and skill of the physician. Most do not question the general leadership role of the physician in the medical supervision of families and individuals and, in particular, his special position in decisions affecting illness and death, but they do state unequivocally that they are no longer willing to accept an auxiliary or purely subsidiary role in the health care process. They feel that the insights and skills they possess can only be effectively used to help people when a collegial or team relationship exists among all health personnel.

Some of these feelings undoubtedly arise from the normal ambition of any group to achieve greater status in the health manpower hierarchy and the consequent emotional (self-image, public image, more education and training, self-government) and economic rewards. More often, they are the result of what are seen as unnecessary restrictions placed on the role these professionals could play by the medical (and dental) profession. Such restrictions are often presented as necessary steps for protecting the public and insuring quality of care. While such motives are worthy, they are not always easy to distinguish from self-interest.

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(1) See pg. 26 for a discussion of community health centres as learning settings for health services personnel.

The Committee feels that community health centres should allow flexible and innovative uses of manpower which will, by concentration on patients' problems, offer more comprehensive care to people. This approach requires the skills of many professionals whose particular contribution varies with the individual problem. We feel that decision-making must be shared and many functions reallocated. Transfer of tasks must not simply be the passing down of unwanted, uninteresting and unrewarding procedures but a proper matching of resource to problem. In addition, the health professions as a whole should use the resources of other people in the community (e.g. clergymen, teacher, youth worker, policeman) and of the general public themselves.

Health professionals feel some unease about the slow response of health services institutions and organizations to changing health care needs and to the impact of technological advance. They also feel a conflict at times between the priorities and desires of the patient and their own objectives and those of the institutions. There is a consequent conflict between the ideal of always doing all one can for a patient and the constraints of practical realities and even the request by society that, in some situations, health professionals act as "rationers" of service.

Many of the concerns of health professionals cannot be eliminated by community health centres. Rather they are a sign of the need to re-organize the health services system, evaluate both the process and the result of care, and, most difficult of all, to remain flexible and open to new ways of doing things. But community health centres can be a major factor in helping to cope with these difficulties and in facilitating the more effective provision of health services.

CONCERNS OF GOVERNMENT AND PROBLEMS OF PUBLIC POLICY

Governments face questions not only in the provision of health services but also in relation to wider issues of public policy.

One of the chief concerns of ministers and treasury board officials is cost -- the high cost of health services, the rapid rate at which spending is increasing and the "open-ended" piecemeal financing arrangements. Cost problems are aggravated by fragmentation and duplication of facilities, by current methods of payment to professionals, and by weak joint planning for facilities, manpower, and services.

Questions of wider public policy involve the more precise delineation of federal and provincial roles in the provision of health services, the assumed right to health care *vis-a-vis* society's willingness to provide the resources necessary to fulfil that right, and the ability of governments to adapt and respond to change.

We would be foolish to pretent that community health centres can cope with all these issues. We do believe that they (and the system of which they are part) can have an impact on costs and the rate at which costs are escalating as well as going a considerable way towards reducing fragmentation and duplication of services. They can make a better use of resources in providing health services to people and do offer a means of better co-ordinating health services with social services. In the area of wider public policy, we feel that the federal and provincial governments now realize they must do more than simply "pay the bills". They must assume an effective leadership role.

> *Reconciling the needed planning and control with the rights of the individual is a political and administrative challenge that must be met if the system is to be workable and if potential economies are in fact to be realized.* (1)

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(1) Ruderman, p. 48.

THE COMMUNITY HEALTH CENTRE - SOME IMPLICATIONS

LEGAL ASPECTS (1)

Although present legislation does not specifically prohibit the emergence of community health centres, it is the Committee's view that appropriate legislation could help to create a climate in which their growth might be encouraged. For example, community health centres should be recognized as legal entities with the status to contract and to sue and be sued.

The concept of community health centre we have proposed requires "corporate" or collective responsibility for the professional actions of all its personnel whatever their individual status in law may be (i.e., irrespective of their position as "independent contractor" or employee). Traditionally, the practitioner has been individually responsible to the patient. That responsibility has been extended to or shared by another person or corporation only where the relationship between the practitioner and that other person or corporation was that of employer and employee. While individuals should continue to be held responsible for their performance, this traditional basis of vicarious liability may not be an equitable or meaningful notion or, indeed, an appropriate mechanism for protecting the patient, in an era of patient care by an integrated team of health professionals in an institutional setting. Such corporate responsibility would complement the team approach since it would foster flexibility and diversity in the provision of care. In addition, direct corporate responsibility would clarify some problems relating to volunteer workers and student health practitioners. At present, it is unclear where responsibility lies for these persons since they are likely not employees of the institution in which the care is provided.

Corporate responsibility would give persons cared for through a health centre redress against the centre for professional negligence on the part of team members, encourage physicians and other professionals to delegate tasks which can safely be carried out by other health workers by removing the basis for their continually expressed belief that responsibility for quality of care resides in them alone, and, finally, would enable professionals and other health workers to enter into contracts of service with the centre and thus give them a sense of security.

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(1) Throughout the following discussion, the Committee has attempted to keep in mind the differences between the common law provinces and the civil law province of Quebec, especially in the light of actual and pending changes in health care legislation in Quebec.

Certification of competence by appropriate bodies and/or institutions, self-governance and discipline by the various health care professions, peer review, and standard setting are issues that have implications for the entire health care system as will be discussed later.(1) At this point in discussing the community health care system it should, however, be noted that precise and rigid fixing of roles, responsibilities and functions of professionals and institutions through statute or licensing regulations would constitute a serious obstacle to the development of effective programs, true teamwork, and innovation. There are, for instance, real disadvantages and practical problems in trying to distinguish a "medical act" from a "nursing act" in a situation where changing and flexible roles are necessary.

Professional licensing legislation will also require review and modification to the extent that statutes currently in force may prevent some prospective members of the health team from becoming true colleagues of other members who are not members of the same profession. The most notable example of an impediment of this kind may be found in the field of pharmacy where, in some provinces, unless the pharmacy legislation is changed, it may be difficult or even impossible for the community health centre to have a pharmacy as an integral part of the centre's services.

EMPLOYMENT OF STAFF

The Committee believes that minimum staffing requirements and broad personnel policies, (terms and conditions of employment, income-ranges, payment methods, benefits and incentives) for particular service entities, including community health centres, should be set by negotiation at the provincial level. Flexibility must be allowed for meeting particular circumstances. But, the actual employment and discharge of personnel and their internal deployment should rest with the community health centre administration. The specific form of employment entered into with a particular staff member could be a general employment agreement for clerical and auxiliary personnel or some form of individual or group contract for professional personnel which would specify the nature of the services, and the conditions under which they would be rendered, including payment arrangements. A group contract arrangement could allow a group of physicians, for example, to distribute the money received for services on a basis agreed to by the centre and the physician group. Specialized personnel serving more than one community health centre should be employed by the area or district administrative level and sub-contracted to the centres.

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(1) p. 33.

PAYMENT OF HEALTH PERSONNEL

Payment methods must permit health services planners to prepare budgets with a reasonable degree of precision. They must promote multi-disciplinary teamwork and a balanced emphasis in service.(1) They must also meet the personal expectations of the members of the health team for adequate, fair and competitive remuneration, for professional status and for requisite professional independence.

Most types of health services personnel are presently paid on a salaried basis. Subject to negotiation and safeguard arrangements, this method would appear to be generally satisfactory. Nevertheless, the use of sessional payment techniques in the case of people wishing to work part time would make possible access to a wider pool of potential staff (e.g. married women).

Some health professionals, notably the physician and dentist, receive their incomes mainly on a fee-for-service basis. There are difficulties in reconciling the planning and administrative interests of the system and the team approach -- both essential for the success of the community health centre -- with the present fee-for-service payment system.(2)

What then are the alternatives? It should first be noted that approximately one-third of the physicians and a small proportion of the dentists in Canada already obtain their incomes from some method or combination of methods other than pure fee-for-service, such as a direct salary or a redistribution of pooled income.(3) Thus, many appear to be willing to work under other payment arrangements provided some degree of choice of method and/or combination of methods is open to them and the levels of remuneration are deemed fair and adequate. It is likely that more would be willing to do so in return for the security of a planned system of remuneration, incentives, and other benefits which could be arranged.

Although at present it is difficult to recommend any one specific form of payment, the Committee agrees that the present form of fee-for-service payment makes the achievement of the objectives of the community health centre impossible. Some Committee members feel that any fee-for-service system is incompatible with the objectives of the community health centre and the health services system.

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(1) p. 2.

(2) For example, it is hard to separate out the work of each team member in any given situation.

(3) The pool of income came as a rule from fee-for-service payments or in an few cases from a block contract arrangement.

The mode of payment for all health and social service professionals in a community health centre should provide remuneration which is adequate, competitive, and includes recognition of the following factors: basic and equitable remuneration for the particular profession, training, expenses, seniority, effort in continuing education, workload (including administration, teaching and research duties), and income security benefits (pensions, sick leave, etc.). Assorted incentive payments for the achievement of specific goals could be helpful.

For remuneration of physicians, dentists, and other professionals who will choose to practice outside community health centres, similar payment options are equally applicable.

It will be necessary not only to experiment with varying combinations of payment methods but also to develop standards, ranges for normal variation in practice patterns, and monitoring and surveillance methods to assure that the interests of both society and the professionals are met. Such sensitive and crucial arrangements can only be arrived at by mutual negotiations among the health services system and the professions concerned. These negotiations could also be used as a mechanism for resolving present recognized imbalances, even inequities, in payment amounts and overall incomes within various professional groups, such as medicine, and between the various professions.

INCENTIVES FOR HEALTH PERSONNEL

Any system of incentives should both give the individual health professional something to strive for and also help in achieving the objectives of the community health centre and the health services system.

The Committee sees the attractions for health personnel to work in community health centres as a combination of the psychological and professional rewards inherent in the challenge of working with others in an innovative team which functions in a responsive and accountable partnership with the community being served, and of the material rewards and benefits possible through working in an organization or large enterprise. The latter tangible benefits should include regularly revised and negotiated minimum levels of basic income for all types of personnel (escalator mechanisms included), guidelines on the application of the possible additional payment methods outlined above, and "fringe benefits", such as shared-cost pensions, life insurance and disability insurance, guaranteed holidays, regular study leave, maternity leave, sickness leave and moving and relocation benefits. These benefits should be set on a province-wide basis, and, by interprovincial agreement, be fully portable across Canada. Other benefits include good secretarial help, adequate technological back-up and pleasant office facilities.

For isolated and "hardship" living areas, additional incentive payments, assurance of adequate housing at reasonable rent, opportunities for continuing education, assurance of good schooling for children (or if necessary subsidization of outside education), regular trips outside the area for personnel and their families, credit towards further professional qualification or preference in gaining entry to further training programs are among the kinds of incentive envisaged. Experience in comparable situations in the health field and in other sectors of life in Canada and elsewhere have indicated the effectiveness of such incentives.

Incentive payments should be made to encourage the achievement of desirable objectives for these new centres, such as keeping people out of inappropriate use of hospitals, limiting to essentials the use of investigative procedures, encouraging consultancy by experts, and promoting health educational activities. These incentive payments should be determined by comparisons of practice profiles with provincial norms and by other external evaluation procedures.

We also believe that governments should consider offering to buy at a fair market price, during an initial time period, existing facilities owned by health professionals such as physicians, dentists and pharmacists, by other individuals and by community groups should they wish to convert their investment. Provision should be made for reasonable integration of private pension and insurance plans into the area of the health services system. These two steps would in our view go a long way to freeing personnel and thereby encourage an improvement in distribution of health professionals.

Although it is a thorny approach, some provinces may wish to consider removing some incentives to the present forms of practice, i.e. they may wish to institute charges for the use by a physician or dentist of hospital, out-patient, and other support facilities. Provinces may also wish to study the possibility of limiting the numbers of various kinds of personnel to be covered through public financing arrangements in areas that are considered "over-serviced" (i.e. area quotas). Additional professionals would be free to locate in such areas but their services would not be covered by medicare; they would be reimbursed on a purely private basis. On the other hand, those who agree to work for a set period in "hard to service" areas might receive first choice when openings occurred in the preferred living areas.

FUNDING

The funding of the community health centre should be tied into the broader financing arrangements for the health services system. Present

financing arrangements must be modified so as to relate to the objectives of the centre and not to remotely designed and fragmented federal-provincial cost sharing agreements.(1)

OPERATING AND MAINTENANCE

It is our view that the community health centre should be financed through a total global budget related to the number and type of population and the nature and scope of services. It should include incomes of professional and other staff and all other operating expenses. This would permit needed flexibility in the planning of service patterns, development of staff, and operating and maintenance funding.

CAPITAL FUNDING (2)

Many of the capital cost problems now encountered by innovative health care programs and most medical group practices will also be problems for community health centres. The difficulties of providing construction capital and funds for the start-up phase of a community health centre must be taken into account.

Capital expenses might be met in several ways. In each case the public must ultimately pay the cost. Direct provincial grants-in-aid could be made to the district health services administration to cover all capital costs, including community health centres. Thus, the community health centre would not be burdened with interest payments or start-up capital expenditures. Grants-in-aid, however, involve large expenditures of monies that might be useful elsewhere in the system. Nevertheless, such grants, given appropriate surveillance measures, may be the most practical way of providing capital funds to health centres in some areas (e.g. northern, semi-isolated) or for specific purposes (e.g. teaching centres, innovative centres for special groups).

Secondly, a province could provide low interest loan capital, again subject to appropriate surveillance measures, to the district health services administration for community health centres. Interest and related costs would have to be included in the block budgets provided to the district health services administration and, in turn, to the specific community health centres.

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(1) pp. 31 and 43.

(2) Ruderman, p. 69. ff.

Finally, private capital sources could be encouraged to provide funds. Such capital might cover construction costs only, with start-up costs being included in the budget of a community health centre in the initial years. Private sources could also build and lease premises to the district health services administration and, if desired, provide maintenance services as well. In short, any of the current construction and leasing arrangements used in the business sector might be helpful in capitalizing community health centres and, thereby, free government funds for other purposes such as providing facilities in areas unable to attract private capital.

DESIGN

The Committee did not attempt to explore in any depth specific designs for community health centres where new physical facilities are required. This area requires further detailed study. However, our investigations and the evidence we had presented to us did lead to certain general conclusions.

1. Good design affects the ways in which services are provided within the facility and can educate professionals to do better work. Design can encourage or inhibit group interrelationships by its physical lay-out and aesthetic qualities. It can indicate a sense of warm welcome to the public and, hence, an openness to their involvement. Considerable research has been done on these more subtle effects of design by architects, engineers, and health professionals; new dimensions of understanding are being added by psychologists, sociologists, interior designers, and others. Further co-operative research and demonstration is required in putting the essential lessons from these various sources into practice.

2. Choice, variation and adaptation of design to meet the precise needs for a given community health centre at any given point in time may be enhanced by using industrial engineering techniques including new computer applications.

3. The potential flexibility and economy of modern building techniques, such as shell and modular construction, and the use of standardized, readily available and easily serviced equipment should be fully explored.

4. Provinces should develop consultant services in the field of design, which go beyond the purely architectural and engineering aspects. A range of model plans should be developed. With federal initiative, a national clearing house of information and ideas should be developed. The interest and support of the professional groups and other private organizations with special expertise in this field should be actively developed through, for example, seminars, design contests, research and demonstration grants.

5. All major building and renovation should be approved at the district and provincial levels in the health services system to assure local conditions, standards, etc., are met.

EDUCATION OF HEALTH PERSONNEL

In a changing field such as health care, regular continuing education and re-education are essential. The community health centre provides a setting for interprofessional and multiprofessional in-service education. The universities and other educational institutions should also provide programs of continuing education and re-education.

A change to a "patient-centred" and "problem-solving" emphasis in educational curricula is necessary if graduates are to be able to function in the community health centre team, with colleagues in the social services and other related services, and the public.

Undergraduate and basic preparation for health personnel must include active learning experience in the work setting of the community health centre if attitudes of personnel and patterns of care are to be changed and greater emphasis on out-patient care is to become accepted as normal. This experience may be gained either through an agreement between a health teaching institution and a nearby district health services administration or through community health centres directly allied to a health sciences centre. Care must be taken to avoid altering community health centres used as learning settings more than absolutely necessary from the usual service-orientation. Otherwise the student learns "ideal" patterns of health care provision which are not duplicable in the real service setting (1) and there is danger that community participation may become illusory.

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(1) Future Arrangements for Health Education. Ontario Council of Health. Monograph 1, 1971. (Mustard Report).

THE COMMUNITY HEALTH CENTRE

SUMMARY

In the light of the three issues noted in the Foreword, the Committee believes that:

1. In order to emphasize community care and to shift service patterns, community health centres should be established and linked with hospitals and other health services in a fully integrated health services system; they must not simply be added onto the present system. Nevertheless, the introduction of community health centres need not await the full integration of the health services system. They are in themselves the catalysts for the development of the new system -- in fact, they are essential to its concurrent development. Community health centres should be established now as non-profit,(1) corporate entities and in sufficient numbers so that new funding methods develop to promote the best use of resources. Enough community health centres must be introduced into the system to allow effective evaluation of their impact on the process of health services delivery.

2. Community health centres must offer a setting where care is provided through a multidisciplinary team. They should allow flexible and innovative uses of manpower which will, by concentration on patients' problems, offer more comprehensive care to people. Payment systems, alternative to the present form of fee-for-service, which are conducive to the team approach and which are attractive to health professionals must be developed.

3. Community health centres must be clearly identified and accessible points where appropriate decisions can be taken about solving people's health care problems. They must promote a better balance between health promotion and prevention, diagnosis and treatment, and rehabilitation. They must, as necessary, relate to other health care services and community social services on a co-ordinated and integrated basis.

4. Community health centres must involve individuals more fully in decisions about service provision as well as in personal and family health care.

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(1) "Non-profit" excludes the standard share corporation where profit accrues only to the shareholders.

RECOMMENDATIONS

The Committee recommends:

1. The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres, as described in this Report, as non-profit corporate bodies in a fully integrated health services system.
2. The review and modification, in consultation with appropriate public and professional groups, of existing provincial legislation and regulatory measures affecting health professionals and practices to allow for flexibility and innovation in service provision. (pp. 19-20)
3. The funding of community health centres through global or block budgets given by the province to the district level covering all capital operating, maintenance, and amortization costs. (pp. 23-25, 30-32)
4. That employment and deployment of personnel rest with the community health centre administration. (p. 20)
5. That payment for professional services in community health centres be based on training, experience, responsibility and workload; that payment systems be equitable, competitive and promote the objectives of the community health centre. (pp. 21-22)
6. That payment mechanisms alternative to the present form of fee-for-service be developed and evaluated in discussions between governments, the health services system and the professions concerned. (pp. 21-22)
7. That measures be developed by governments, in concert with appropriate public and professional groups, to assure that community health centres and the professionals working in them make the most appropriate use of other facilities, such as hospitals, and programs in the health services system. (p. 23)
8. That scientific evaluation of the impact of community health centres on the health of the population served and on the overall costs of the health services system be co-operatively carried out by governments, universities, educational and research bodies, and professional groups during the planning, demonstration and implementation phases; that regular evaluation, through professional and administrative audit mechanisms (internal and external), of performance and utilization become an integral part of the operation of a community health centre. (p. 36)
9. That by agreement between the provincial, district and university health authorities, designated community health centres be affiliated with university health sciences centres and other educational institutions for the preparation of health and social services personnel. (26)
10. That the development of integrated health and social service centres in various settings be studied and evaluated by government, the universities and professional groups. (p. 9)

11. That a comprehensive and co-operative campaign by governments, professional groups, and community and citizen organizations be carried out to inform the public and the health professions of the objectives of community health centres. (pp. 14-17)

THE HEALTH SERVICES SYSTEM

The community health centre is one way of controlling costs, introducing new patterns of care, and providing a communications network to put people in touch with services when they need help. But our investigations have led us to the conclusion that **real economies in using resources to meet the needs of people can be achieved only if the community health centre is part of a health services system which is fully integrated administratively and financially.**

It must be kept in mind that health services even when under different administrative and funding authorities are, from an economic viewpoint, indivisible.

> *"The share of national product devoted to the health care sector comes from a single source: [the public]. Its allocation among the agencies or functions involved in the health care system--- can be viewed as a single transfer payment. The greater the freedom to reallocate funds among the various functions that comprise the total health care system and the greater the emphases on co-ordinated planning for the system as a whole, the greater is the probability of achieving the most rational use of resources...*(1)

In the Committee's view, the logic of these statements is indisputable. We believe the present health services system requires reorganization.

PLANNING AND ALLOCATING RESOURCES

Any body can only take effective decisions to the extent that it has power to implement those decisions -- in other words, upon its freedom and capacity to plan and allocate resources.

PROVINCIAL POWERS

The Committee believes that **the provinces must retain the major responsibility** and the ultimate approval for planning, allocation of resources, and evaluation. But, we also believe this must be done **in concert with the professions and the public** and should not be on an "all or nothing" basis. **The provinces must be prepared to delegate** to the district or area level of administration -- subject to basic guidelines, standards of province-wide equity and a system of accountability -- **sufficient responsibility and power in these three areas to meet local needs.** Only through such a system can responsible public involvement be achieved.

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(1) Ruderman, p.

More specifically, the province must have the major responsibility and ultimate decision-making authority for:

1. Planning the overall pattern of services and the basic levels and standards for specific services to assure balance and equity throughout the province.

2. Planning and maintaining an effective manpower policy attuned to the needs for obtaining, distributing and retaining the kinds and numbers of health personnel required to meet provincial health objectives.(1) This requires effective joint planning between the ministries responsible for health services, education and labour. This would include the development of province-wide uniform standards of qualification, the establishment of effective negotiating arrangements between the health services system and professional associations, syndicates, and unions which are increasingly assuming the functions of area-wide bargaining units for income scales and terms of employment. Health personnel would, thus, be assured of easy province-wide mobility and choice in work setting.

3. Establishing appeal mechanisms, as outlined elsewhere in the Report, to deal with any grievances.(2)

4. Assuring the money necessary for meeting the plans and standards established and approved for the health services system. We believe that this requires the allocation of funds on a block or program budget to the district or area health services administrations in line with budgets submitted by them for provincial approval.(3) In order to achieve equity and balance, the block budgets would probably have to consist of two elements: first, a per capita cost or experience portion and, second, an additional portion aimed at raising the service level in economically disadvantaged districts or areas.

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(1) Provincial manpower policies should be interrelated in a national manpower policy and clearing house system to the fullest extent possible in order to get the benefits of a nation-wide use of manpower resources.

(2) p. 43.

(3) At the early stages in the establishment of the health services system, the block budget would probably be based on the experience of the current component programs but as integration of services and programs increased and began to affect service patterns, for example, reducing hospital in-patient use, effective and efficient rationalization of services through real program budgeting could be developed.

5. Providing the province-wide communications and records systems, including the central records storage and data processing services.

6. Assuring an ongoing evaluation of the provincial health services system, district or area sub-systems, and the individual program and service elements by measuring them against province-wide basic standards and the extent to which overall objectives for the health services system are being met. Evaluation is also essential for planning and taking decisions about changes in priorities, programs, and resource allocation.

We have considered the possible addition of larger regional administrations between the provincial level and the district or area health services boards but we feel that these may be required only in large provinces or for special political reasons. Otherwise, the regional level merely adds another layer to the decision-making process with consequent delays and loss of flexibility.

DISTRICT OR AREA POWERS

The district or area health services administration should have authority for:

1. Detailed planning and development of proposals for the priorities and kinds of services within its area, consistent with the provincial health services system requirements and subject to final overall budgetary approval by the province. This will require planning: first, to meet the basic provincial standards and, second, to put forward additional proposals which the community feels are appropriate to its area. Detailed service planning includes determining the location of community health centres and basic medical and dental units within its area, deciding which elements would be developed as specialized service centres, and shifting service patterns from an institutional basis to a program basis (e.g. a cardiac care program might include facets of service now in hospitals, health units and home care programs).

2. Assuring an effective link with other personal services in the district.

3. Developing an effective area manpower recruitment, retention, and in-service education program.

4. Compiling the budget requirements for individual services and facilities in its area and presenting a total "package" to the province. No building, renovation, or program should be begun without the approval of the district or area administration but the province may decide not to accept the total program budget.

5. Distributing the funds to the specific services and programs in its area.

BOARDS

The community health centres, hospitals and other institutions of the health services system should be corporate entities and, therefore, require some sort of responsible governing body. The composition of these boards and their functions is outlined later.(1)

REGULATORY AND LICENSING BODIES

The Committee is convinced that the positive effects of regulatory bodies, whether they are licensing or merely certifying in nature, in ensuring professional competence would be strengthened if the appropriate role and responsibilities of the regulatory body were clearly understood by members of the profession, the public and governments. The regulatory body of each health care profession, in the Committee's view, exists to protect the public and not to advance the interests of the profession; this latter and clearly important function is properly the concern of the voluntary professional association. To ensure effective community and individual involvement in the mechanisms of the health system, there must be an effective "lay", that is, non-professional, participation and representation on the regulatory bodies of the health professions. Professional statutes should be amended, where necessary, to ensure that no profession can directly or indirectly, regulate the members of another profession or occupation. Amendments of this kind would also have the effect of eliminating the inhibiting effect which some licensing statutes, for example, provincial Medical Acts, have on the rational allocation of functions or roles among members of different health professions.

In order to facilitate effective manpower policies, allow choice of work location and portability of benefits, and take into account the mobility of professionals and patients, the Committee feels that the legal mechanisms and standards relating to roles, responsibilities, functions and institutions should be as uniform as possible from one jurisdiction to another in Canada.

We are aware that laws and standards cannot guarantee the highest quality medical care and that, realistically, they may only be able to secure protection against very poor health care. But we do not wish to underestimate the value of licensing regulations and legislation as positive educational and guidance tools.

PROVISION OF DRUGS

We have noted that the fullest involvement of the pharmacist (2)

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(1) pp. 41-42. As noted, the district board could fulfil these responsibilities in certain circumstances.

(2) See pg. 14.

as a drug usage consultant, peer review of prescribing practices, and the development of patient profiles, the use of regularly revised drug formularies, bulk purchasing and prepackaging in suitable unit amounts (1) can provide economies consistent with quality in a community health centre. However, the real value of these approaches can only be achieved through a health services system. Any steps taken by a province should involve co-operative dialogue with the pharmaceutical manufacturers and distributors and the health services personnel involved in drug provision. Where pharmacists remain in solo practice they should be included in the district health services system and more fully used in the consultant role. A health services system allows the development of a drug information system and the many advantages for quality care and evaluation flowing from it.

PUBLIC HEALTH PROGRAMS

Within a reorganized health services system, many personal services presently provided by public health programs, especially by public health nurses, could be provided through the community health centres. But there remain essential public health functions, such as epidemiological surveillance, the assessment and evaluation of community and area health problems and services, the development of area preventive programs and co-ordination and control (2) over their application (for example, immunization levels, selected screening programs health education), and the protection of the environment from a health standpoint, which cannot be delegated to community health centres. These public health functions must continue to be carried out on area-wide, province-wide and, in certain instances, country-wide bases through the health services system.(3) Direct personal preventive programs, such as public health nursing, will continue to be required for people obtaining their health care from sources other than community health centres.(4)

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(1) Care in carrying out such steps should be taken to assure that a stimulus for pharmaceutical research continues to exist in Canada.

(2) The area authority must be able to control, as necessary, essential protection services; however these may be usually carried out in community health centres.

(3) This may be a separate public health program under the district and other administrations. In Quebec under Law 48, it will be carried out through designated hospitals. Also see Crichton p. for further discussion of this matter.

(4) For example, from existing types of solo and medical group practice.

MENTAL HEALTH SERVICES

The community health centre by involving the public (1) and using the multidisciplinary (2) team, including the clinical psychologist and other mental health personnel, provides a setting in which there can be greater emphasis on the psycho-social aspects of care. A health services system makes the wider involvement of all the community's potential "front line" mental health resources (clergy, teachers, police, recreation counsellors, voluntary agencies and the public themselves) easier to achieve. However, consultant mental health teams and services must continue to be provided for referral and for support of community health centres and other basic care settings.

REHABILITATION SERVICES

As to rehabilitation services, our observation is that their provision is also presently fragmented among a variety of public and voluntary institutions and programs, and an increasing number of private agencies. It is our view that those programs which emphasize medical rehabilitation can best be rationalized through the health services system. Community health centres as a rule should not include more than basic medical rehabilitation facilities and personnel whenever fuller services are available through hospital and rehabilitation centres in the community area. It should, however, be noted that there is a whole field of vocational rehabilitation which is essentially in the social service, education and manpower fields. There are also rehabilitation services for the socially disadvantaged where the main problem is not health. Specific cross-relationships among health oriented programs and these other rehabilitation programs are necessary, since it is often difficult to separate the different aspects of rehabilitation into distinct programs.

EXTENDED CARE FACILITIES

Convalescent and chronic care institutions, nursing homes, "half way houses", and other extended care facilities must be integral components of the district health services system. Rationalization of the use of these facilities and funding arrangements for them can then be achieved. In addition, the system would permit more effective continuing medical, nursing, and other care and supervision in these facilities. A health

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(1) See p. 41 ff.

(2) See p. 2 ff.

services system which is intimately related to the social services also makes possible easier provision of health care to residential facility settings. The social service contribution to the direction and program of extended care institutions is important in assuring the quality of life, as well as the quality of care, for the people in these institutions.

HOME CARE PROGRAMS

Although some home visiting for initial diagnostic and/or simple therapy as well as for health education purposes will be carried out by public health nurses and other personnel in community health centres, the need for a co-ordinated home care service, including visiting nursing, visiting homemaker, chiropody, and other social services (child care counselling, friendly visiting, etc.) will remain. Because these programs are not only for the ill but also for people with any need requiring home care, it seems advisable for such services to be jointly provided through the district health services administration and its counterpart organization(s) in the social services area.

DAY CARE

Community health centres may decrease the need for in-patient hospital care and may relieve burdens upon families by developing day care services for geriatric and mentally disordered (disturbed and/or retarded) patients when they require minor surgery and investigative procedures. Moreover, 8-hour "sick-child" care for the children of working mothers might be made available. The extent of these services would depend upon the availability of staff and development of volunteer services. This is an activity which could integrate the community health centres more closely into the local community.

VOLUNTARY HEALTH AGENCIES

Voluntary health agencies should be encouraged to continue their emphasis on innovative and demonstration programs to meet special needs of particular groups of people as well as their roles in public and professional health education and in research. They may also be usefully employed on a contractual basis for carrying out official programs. But they must become integral components in the district health services system in order to prevent duplication of effort and permit equity in funding. This may be achieved by provincial insistence on co-operation and basic standards as a requirement for receipt of public grants, contractual funds, or preferential tax status.

EDUCATION OF HEALTH PERSONNEL

The fundamental intellectual independence and research characteristics of the education system must be respected; at the same time the education system must be responsive to the manpower needs of society. Serious over or under production of certain types of health personnel (1), curricula which fail to reflect modern advances in science, technology and in social organization, and courses which are "closed ends" for those who take them result from unco-ordinated planning between the health services system and the education system.

Rigid use of specific types of personnel, slowness in responding to new work patterns and skills, failure to include effective planning, evaluative, and research functions are examples of the fragmentation which we see requiring urgent attention.

Admission requirements for the various health professions should be set jointly between the educational institutions, the profession concerned and the public interest as represented by government to assure courses which realistically balance the educational needs of the individual in modern society and the functions he will be expected to fulfil in the health services system.

Curricula should be designed to give as much academic credit as possible to personnel wishing to transfer their area of work in the health field or to become more specialized. Practical experience, although sometimes hard to equate with academic experience, should be taken into account.

Finally, the educational institutions and the health services system must co-ordinate the planning and provision of continuing education programs. At present these programs, both in-service and extra-mural, tend to be developed on an *ad hoc* and individually planned basis by specific educational insitutions and/or by specific health services. The changed emphasis within the health services system will require a much more extensive educational program and co-operative approach if the need for skilled manpower is to be met.

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(1) The supply requirements will vary in time and place with factors such as the way various types of personnel are used and with the impact of scientific and technological advances .

EVALUATION AND INNOVATION

An essential element in the development of the re-organized health services system is careful and on-going scientific evaluation. This will allow the appraisal of the result of the new methods of health care delivery, as well as of existing approaches, and different treatment theories and concepts. It also will allow for an assessment of alternative methods for reaching the desired outcomes and objectives of the health services system. The evaluation process should involve the expertise of a variety of specialists including health care administrators, epidemiologists, social scientists, economists, and finance and managerial personnel.

A sufficient portion of budget will, therefore, be required for an evaluation of new projects both in the design and demonstration phases, and for training the various types of personnel to carry out evaluation procedures.(1) In addition, operating budgets in the health services system should provide for regular on-going evaluation of new and existing projects through internal and external auditing of performance and utilization.(2)

It is vital that a record system be employed, in community health centres and throughout the health services system, which is capable of supporting the activities of teaching, monitoring of norms, and evaluation.

THE COMMUNICATIONS NETWORK

Since many health professionals are now grouped together because of difficulties in communication and service referral, the establishment of a communications network would permit greater variety and flexibility in the forms of services provision within the community or within a given facility. In fact, such a system could encompass more than simply health services; it could be the principal means of co-ordinating the health and social systems.

We feel that the communications network is a basic requirement for assuring a dynamic, responsive and co-ordinated health services system. Without a communications network, the present problems of fragmentation of health services cannot be solved except through a rigid hierarchical bureaucracy such as has grown up in several other countries.

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(1) Some monies are now available through federal and some provincial granting arrangements but more will be required if substantial changes in the health services system are carried out.

(2) There may be significant and important costs to the individual and family (through such factors as loss of income from time off work, convenience, and costs of supporting care of people in the home) which also require evaluation.

THE TECHNOLOGICAL COMPONENT

A linkage system built upon elements now available (telex, telephone, radio, television, computer systems) would allow the health system to be rapidly responsive to the particular needs of any individual patient, professional, and service facility. Such a network would enable prompt referral to services and facilities, avoid duplication of record-keeping, facilitate consultation and continuity of care, and allow greater choice for an individual of initial, continuing and referral care settings. It is directly suited to the increasing mobility of part of our population while permitting those who chose to remain in one location to obtain most of their care through a single service point.(1)

Once the basic levels of service are established, we feel the introduction of modern communications technology into the health services system should assume a top priority for planning and expenditure at federal and provincial levels. This priority applies particularly to the development of modern management information systems.

REFERRAL SYSTEMS

One of the issues which must be resolved in a health services system is the question of patient referral within the system. At present, since each hospital and each specialist clinic is an independent entity, it is hard to get agreement in an area or district for any one hospital or clinic to be built up as area referral centres and thereby attract and support a good cross-section of specialist medical nursing, and other personnel. Present patterns often lead to the appropriate referral centre being bypassed by nearby physicians and patients. This is partly because of feelings of physicians and the public that a university teaching centre may be a better place for all specialized care. But it is also related to the fact that many specialist groups do a considerable amount of general family care, and are, therefore, in a competitive position with the family physicians. We believe that a health services system, including the modifications in payment we have suggested, would resolve the problem of competition for fee income and, through the planning and funding functions of district or area boards, permit the development of adequate district referral hospital and other specialist referral services.(2) It could also provide a mechanism for assuring a hospital relationship for all district physicians.

The consultancy and specialized referral functions of the university, especially those of its health sciences centres must be more fully developed. In the present health services pattern, the university centre

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(1) Confidentiality of records can be assured by special coding and retrieval techniques.

(2) pp. 21-22, 41.

with its teaching clinical personnel and hospitals cannot attain its full potential because it competes for patients (and therefore for funds) with non-university personnel (especially physicians) and hospitals. Only an overall health services system which eliminates this competition can allow a full development of specialized referral and consultancy services. We see the health sciences centres as fulfilling these functions not just for one region or province but for a number of regions, several provinces, or even nationally. Rigid regional and provincial parochialism, all too evident today, are major barriers to the full exploitation of the potential of the health sciences centres. Some equitable solution must be found to the funding and jurisdictional problems presently existing as reasons, sometimes excuses, for lack of co-operative planning and use of such resources. We believe that the payment proposals for health professionals, especially physicians, made earlier in the Report (1) would help in reducing the importance of income as a competitive factor.

LABORATORY SERVICES

Provincial laboratory services and larger hospital laboratories have demonstrated over the years a capacity to provide economic and accurate test results with a minimum use of expensive supervisory personnel. However, they have been unable, because of budget restrictions and bureaucratic constraints, to compete on equal terms with private laboratories. Partly because of this, private, automated laboratory operations have developed which have been reimbursed on fee schedules for older manual methods. The fees have permitted quick and high profits to these private laboratories which have, in some cases, amounted to a markedly increased cost to the public purse. An additional consequence is that duplication of laboratory services, with built-in incentives to excessive utilization, has developed. The increasing costs of laboratory services have deleteriously affected other parts of the health care system.

What is required, therefore, is the development of provincial laboratory systems, without duplication and without incentives to excessive utilization, which fully exploit the resources of private, hospital, and provincially-owned laboratories. In particular private laboratories should be required to equal or improve upon costs and services of hospital or provincially-owned laboratories.(2)

As noted previously, community health centres should as a rule provide only very basic, common and easily done laboratory tests.(3) Whenever possible other work should be done through the improved and unified provincial laboratory-hospital laboratory system.

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(1) pp. 21-22.

(2) If a fee payment schedule is retained, the professional medical component should be separated in payment from equipment and technical staff costs wherever possible - e.g. electrocardiograms and other special diagnostic procedures.

(3) pp. 4, 14.

DIAGNOSTIC RADIOLOGICAL SERVICES

In the case of diagnostic radiological services, we have again seen in other studies and noted in our own investigations that there is considerable overprovision and underutilization of sophisticated equipment. Competent technicians and professional supervision are not always as available as quality and safety demand. It is our view that the more expensive and sophisticated diagnostic equipment and staff should be located in the major hospitals or other referral settings within each district health services system. Community health centres should only, as a rule, have simple radiological equipment suitable for common diagnostic procedures (e.g. - fractures, chest films, etc.) and this equipment must be regularly inspected for quality and safety.

EFFECTIVE PUBLIC PARTICIPATION

Public involvement can only assure effective service when boards develop a recognition of what quality service is and how to go about obtaining it. The role and authority of any board must be defined very early and very precisely. Without this process, a board's enthusiasm and its impact on service provision that frequently occurs in the initial stages of its existence can be dissipated.

Misunderstanding of its role and authority can lead, for example, to frustration in a board on discovering in certain instances that it is an advisory rather than an implementing body, or to friction because the board has impinged on the management function intended to be performed by staff. Such situations immobilise a board's efforts towards effective action.

Great care needs to be taken to ensure that boards are in a position to provide the dynamic and continuing contribution of which they can be capable. This should be in their defined area of policy and program development and decision-making, and as conveyors of informed concern and opinion between the community and the agency.

DISTRICT OR AREA BOARDS

We believe that a health services system must be responsive to the priorities set by the community. Thus, we believe that the district or area health services administration must be a representative public board. The district health services board must be supported by administrative and other professional personnel to help it gather and assess data, to plan, to implement and to evaluate its functions.

The staging of the introduction and assumption of full responsibilities and the exact composition of the district or area health services administration board should be determined by each province according to its own circumstances; we feel the following general ideas are essential.

1. There should be representation from citizen organizations, voluntary agencies, municipalities, and the province. All members should regard themselves as area-wide representatives and not only as representatives of a particular interest group.
2. Any professional and/or institutional representation should be commensurate with the technical and administrative knowledge required for responsible board functioning.
3. There must be a means to assure that significant minority group interests are represented.
4. Continuing education of the board and means for regular introduction of new members are essential.
5. The selection and functioning of the district or area health services board must reflect the essential element of accountability in our system of democratic government.
6. There should be a technical advisory committee to advise the district or area health services board about technical and professional questions.

INDIVIDUAL SERVICE BOARDS

The formation of a district or area board should not necessarily mean that all existing hospital, institutional, and health agency boards cease to exist. For many years hospital and other boards have worked successfully to raise the level of care for the people served. So much has this been the case, that efforts are now being made at various government levels to establish boards for mental hospitals, veterans hospitals, and tuberculosis sanatoria as a means for improving standards of care and responsiveness to need and to scientific advance. Moreover, major impetus for concepts of accreditation, audit and peer review as means for raising standards of patient care has come from active and sensitive citizen boards and administrators.

On the other hand in rural and smaller urban communities where relatively small institutions and services exist, it may be wise for many reasons (political, administrative, planning, staffing) for the district or area board to assume responsibility for all services or to establish local health boards for each community in the district. Any change, however, will only be successful where careful attention is given to preparatory education, dialogue and involvement of the public, the existing boards, and the health professionals in a district.

It should also be noted that the responsible corporate body in a hospital or institution is the board. It can sue and be sued. It can, if it wishes to assume its full powers, have a material effect on the priorities and quality of care, through active standard setting, approval of staff appointments and through emphasizing patient priorities in relation to those of the health professionals, education, and research. There is, of course, ample evidence that many boards do not in fact live up to their potential. But this is not a reason for eliminating them. Rather it indicates a need to strengthen them through being part of a health services system of the type detailed.

Should all community health centres have boards? The Committee feels that the decision should be made on exactly the same bases as just outlined for hospital and other service boards. If a board can serve useful purposes then it should be established; in other instances these purposes may better be fulfilled by the district or area board.

COMPLAINTS AND GRIEVANCE MECHANISMS

In each district, a body to handle grievances and complaints, both of the public and of health professionals, with powers to investigate situations and redress wrongs should be established. This body must have its own budget and staff separate from the district or area health services board, so that it is free to effectively carry out its responsibilities. It should be directly related to the provincial ombudsman's office or to the provincial health ombudsman's office, where one exists.

MONITORING AND EVALUATION BODY

At the provincial level there should be an independent body with its own budget and staff with the responsibilities to monitor and evaluate the performance of existing and new programs and of the health services system as a whole and in co-operation with the universities, professional groups, and other expert resources. Findings should be made public on a regular basis. As the new health services system develops, these essential activities might, in the larger and more populous provinces, be carried out at the district level with particular reference to the services in the area. Several smaller provinces may wish to carry out their functions on a co-operative basis.

The federal government should continue to carry out national evaluation studies and co-operate with provinces desiring mutual studies.

FINANCIAL IMPLICATIONS OF A HEALTH SERVICES SYSTEM

There are fundamental financial implications in our proposals for a health services system which places greater emphasis than at present

on various forms of out-of-hospital care, including community health centres.

Because of the proposed shift from in-patient care and institutional care, greater responsibility for health maintenance and care falls on the individual and the family. This new emphasis will incur increased cost and inconvenience to families. Public schemes for financial coverage will have to be extended to forms of basic care other than hospitalization and physicians' services, (1) such as extended care, home care, out-of hospital prescribed drugs, and dental services. Payments will be necessary to permit a family member to give care in the home or to employ someone to provide it without loss of earning potential for the family. (2)

Extra money may also be required to cover increased social work costs, absorb the expense of necessary transportation, etc.

Without such incentives the pull of presently insured services and of institutional forms of care will continue to be irresistible for people, even though they may often be more costly to the public purse as a whole.

If a province were simply to introduce community health centres, a reduction of in-patient hospital costs would not automatically follow. Community health centres and an integrated health services system can make possible greater value for the money spent on health care. But this will require hard decisions to set ceilings and to hold the line on the amounts of capital and operating funds available for various existing facilities and services in order to divert a greater proportion of money to the newly emphasized out-of-hospital services, including community health centres.

This will not be either politically or socially easy in many communities and areas. Although some of the money needed could, therefore, come from transfers and from the greater efficiencies in resource use, it is clear that additional substantial amounts of money will be required. "Seed" and "changeover" monies such as the proposed federal thrust fund of $640,000,000 and similar provincial sources are fundamental to the changes we have described.

There is a further facet to the funding picture. Visits to each province revealed wide variation of service levels not only between areas of the country but also within the provinces. Despite inter-government

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(1) Additional charges for covered services should be avoided.

(2) As is now the case under Workmen's Compensation provisions.

cost-sharing arrangements and income redistribution programs, there is clear evidence that within Canada the speed of change has widened the gap between the extremes of health services provision. The present federal proposals to the provinces on new cost-sharing arrangements in the health care field do contain an important element of financial redistribution in favour of the less wealthy provinces. Even so, it has been suggested to us that the proposals do not sufficiently allow for the basic problem. Some provinces do not have enough money to make the necessary system changes and to achieve a standard of service equal to the wealthier provinces.(1)

It should also be noted that the proposals do not include arrangements on welfare cost-shared programs, such as the Canada Assistance Plan, which contain substantial health care provisions, or which affect social services and community facilities, such as homemaker services and homes for the aged, etc., with a direct bearing on health services provision. In this sense, social policy and economic policy are indivisible.

It is not our place to enter into the merits of the social and economic policies and proposals of either the federal government or any provincial government as they affect the present negotiations on shared cost health programs or into the sometimes difficult constitutional jurisdiction questions involved. But we do stress that if nationhood means anything, it requires a common basic standard of service throughout Canada and within a province and territory.

The magnitude of the amounts of money these essential changes will require may at first glance appear as a powerful argument against our recommendation. However, further thought reminds us that the alternative is a steady worsening of our capacities to provide and fund the health care which scientific and technological advances will make possible and our people will expect.

In the Committee's view, we have no choice as a responsible nation but to take the fundamental decisions for change presented in this Report.

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(1) It is, of course, clear that changes in the health services alone are not the answer to poverty and underdevelopment.

THE HEALTH SERVICES SYSTEM

SUMMARY

In order to make community health care a priority and to fully achieve the goals noted in the Foreword, the Committee believes that:

1. All health services must be integral parts of a health services system. This entails a whole-hearted commitment to common objectives and policies established through dialogue among governments, the professions, and the public.

2. Health care is becoming more and more accepted as a right. This idea must be defined and acceptable boundaries placed on it, if society is to give rational direction to the planning, financing, development and evaluation of health services. Just as the concept of right must have its limits defined, so also must the idea of choice for the individual whether as recipient or as provider of service. These two concepts must be consistent both with the prevailing ethical and moral bases in Canadian society and with the willingness and capacity of society to allot the necessary resources for the attainment of broad health objectives. Some type of device acceptable to society must be found for distributing the resources available at any given point in time.

   There must be an acceptable level of equity in availability and accessibility of health services for all Canadians. This does not preclude additional special help in meeting the basic level for provinces or areas with special economic and other needs.

3. Creative planning and use of resources in furthering local priorities in addition to wider provincial and national ones requires some degree of decentralization of planning, policy setting, budgeting and implementation. Clear definition of functions, responsibilities and powers is necessary at all levels. All responsibilities and powers must be exercised so as to assure provincial and national basic standards of availability and accessibility.

   Although the Committee recommends decentralization, we recognize the wisdom of central planning and administration within a province, or group of provinces (or even federally) of certain services.(1)

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(1) e.g. data bank, manpower licensing and clearing house, surveillance and monitoring of services, laboratory services, watershed control, cancer radio-therapy, highly specialized rehabilitation (thalidomide children),etc.

Decentralization in the actual delivery of a service (as in the case of laboratory services) does not preclude such central planning. Account should be taken not only of political, economic, and communications areas but also of technological, referral, and consultation resources (e.g. health sciences centres).

Responsible and effective exercise of power requires substantial availability and control of money through some form of global or block program budgeting.

Federal-provincial cost sharing should encourage effective provincial planning. In turn, provincial financing arrangements with district and/or local areas should encourage effective planning, consistent with both the wider national and provincial interests and equity.

4. There must be clear information, referral and planning links between and among all elements in the system.

5. Any health services system can function effectively only when participants are willing to work together. They must all accept the responsibility to understand the purposes of services and use the system wisely. This will require a massive and continuing information and education program. It will mean real compromises and difficult decisions. It implies the active involvement of citizens in planning, advisory and policy making bodies, such as regional and individual institutional boards, whether government or voluntary. In order to assure equitable treatment within the system, grievance mechanisms are necessary for both recipients and providers of service.

6. Continuous evaluation, assessment and regular reporting of the extent to which policies and services work towards the achievement of objectives are necessary. Internal and external audit and review methods carried out under appropriate public and professional auspices must be integrated into the health services system.

RECOMMENDATIONS

The Committee recommends:

1. The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.

2. The immediate initiation by provincial governments of dialogue with the health professions and new and existing health services bodies to plan, budget, implement, co-ordinate and evaluate this system; the facilitation and support of these activities by the federal government through consultation services, funding, and country-wide evaluation.

3. The establishment by the provinces of district or area administrations consisting of

   (a) a representative citizens board and

   (b) a technical advisory body. (pp. 41-42)

4. The use by provinces of program or block budgeting methods in the health services system.(p.31)

5. The fullest practical introduction by federal and provincial governments of modern communications technology into the health services system.(p.39)

6. The development by provincial government through negotiation with the professions and with new and existing services of less-costly and more appropriate alternatives to acute hospital in-patient care; coverage for these alternatives and for care in the home under federal and provincial "health insurance" schemes. (pp. 10-12, 44)

7. The setting by governments, in negotiation with appropriate public and professional groups, of priorities for allocating funds for new and existing facilities. (pp.30-32, 44)

8. The reduction by provincial governments of acute general hospital in-patient bed facilities.(pp. 10, 44)

9. The development and co-ordination at federal, provincial and inter-provincial levels of manpower policies, funding policies, educational programs and teaching curricula to assure an appropriate supply of personnel for the health services system. (pp.31, 21, 37)

10. The seating by provincial statute of representatives of the general public on professional licensing and regulatory bodies. (p. 33)

11. The development by the provinces of adequate grievance and complaints bodies with powers to investigate and to redress wrongs. (p.43)

12. The regular scientific evaluation of all planning, demonstration, and implementation of new and existing health services and of the overall health services system in terms of performance (including quality) and utilization, by the provinces, universities and other education and research resources, and professional groups in mutual co-operation. (p.43)

APPENDIX A

1. TERMS OF REFERENCE
2. STUDY METHODOLOGY

TERMS OF REFERENCE

The terms of reference of the Community Health Centre Project as approved June 30, 1971:

1. To collect and assess information on existing types of Community Health Centre in Canada and in other selected countries.
2. To identify the objectives and characteristics of various kinds of Community Health Centres as parts of the health delivery system. Alleged or expected advantages should be assessed.
3. To describe models of Community Health Centres recommended for development in Canada.
4. To identify possible problem areas in the development of Community Health Centres of various types in Canada and to recommend ways of dealing with them.
5. To describe in detail important economic characteristics and incentives such as government grants and loans, and the operating and capital costs relating to different models of health care delivery through Community Health Centres.
6. To explore important social, psychological considerations involved in the development and operation of primarily comprehensive continuing health care units in Canada as they relate to professional and consumer acceptance.
7. To recommend on the desirability of more active development of specific kinds of Community Health Centre in Canada on:
   (a) a demonstration-research basis
   (b) a general service basis
8. To recommend on the possible roles of the various levels of government and other interested groups in Canada in the development of Community Health Centres.

STUDY METHODS

Within the constraints faced by the Project of time, data collection, lack of information in some aspects, and the level of present analytic and predictive skills, the study approach had to be essentially one of bringing together and reviewing knowledge and experience which already exist in Canada and elsewhere. Based on the evidence as we could obtain it, the Committee then made judgements and prepared its recommendations. Specifically, the following five approaches to obtaining data and evidence were followed:

1. A review of available Canadian and other literature and supporting documentation on ambulatory care methods and services in general and on various types of health centre in particular.

2. The carrying out of specific expert studies and analyses of specific issues, problems and experience, including case studies, on a wide range of practice and health centre "type" programs. In all, some 100 expert papers are included. Two major papers synthesizing the studies, one on economic and cost implications and one on community and organizational implications, were prepared.

3. Special seminars were held to elucidate issues and attitudes on specific topics related to community health centres. Expert resource papers and summary papers were prepared for each seminar. Some Committee members participated in each seminar. The topics included:

   (i) Personnel implications, functions, education, and relationships for:
   - (a) - physicians
   - (b) - nursing
   - (c) - dentistry
   - (d) - pharmacy and drug dispensing
   - (e) - social work services
   - (f) - allied health personnel
   - (g) - administrative and managerial personnel.

   (ii) Issues and relationships with other organized service components:
   - (a) - hospitals and related institutions
   - (b) - public health
   - (c) - mental health
   - (d) - social services

   (iii) The general impact of design on service patterns and use

   (iv) Issues and problems related to citizen, consumer and community involvement

   (v) Issues and problems in relating health services to overall social policies and services.

   (vi) Legal issues and problems

   (vii) Special issues and problems in federal-provincial cost-sharing and in payment methods for services and facilities.

4. An appraisal was made through selected site visits and appropriate supporting documentation of existing and proposed programs in Canada, the United States, the United Kingdom and certain other European countries. As further support for this part of the study, two expert analyses of American and British and other European experience relevant to Canada were done. Visits were made to consult selected persons in governments, the health professions, educational institutions for health personnel, and citizen groups with health interests across Canada.

5. Written briefs and supporting documentation were solicited from several hundred government, citizen, and health professional organizations across Canada. Letters were published in selected professional journals. A notice appeared in major newspapers, both English and French, across Canada inviting individual experience and comments from anyone wishing to write to us. Finally, all federal senators and members of parliament were invited to send comments based on the particular situations in their own constituencies.

APPENDIX B

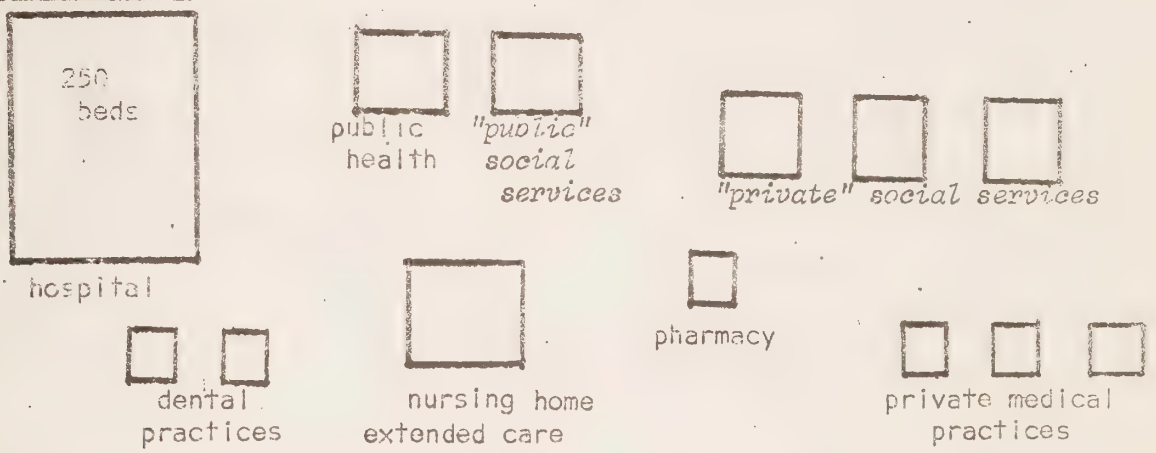
DIAGRAMMATIC PRESENTATION OF

1. AN URBAN HEALTH (AND SOCIAL) SERVICES SYSTEM
2. A RURAL HEALTH SERVICES SYSTEM
3. A COMMUNITY HEALTH CENTRE
4. A COMBINED HEALTH AND SOCIAL SERVICE CENTRE

1. URBAN HEALTH (AND SOCIAL) SERVICES SYSTEM

Diagram 1 shows a possible urban system based on an existing community hospital in a growing district (pop. 50,000) of a large metropolitan city (pop. 500,000). The social service components are shown in italics. If they are excluded, the diagram shows a health system; if included, a health and social services system.

PRESENT FACILITIES



REORGANIZED HEALTH (AND SOCIAL) SERVICES SYSTEM

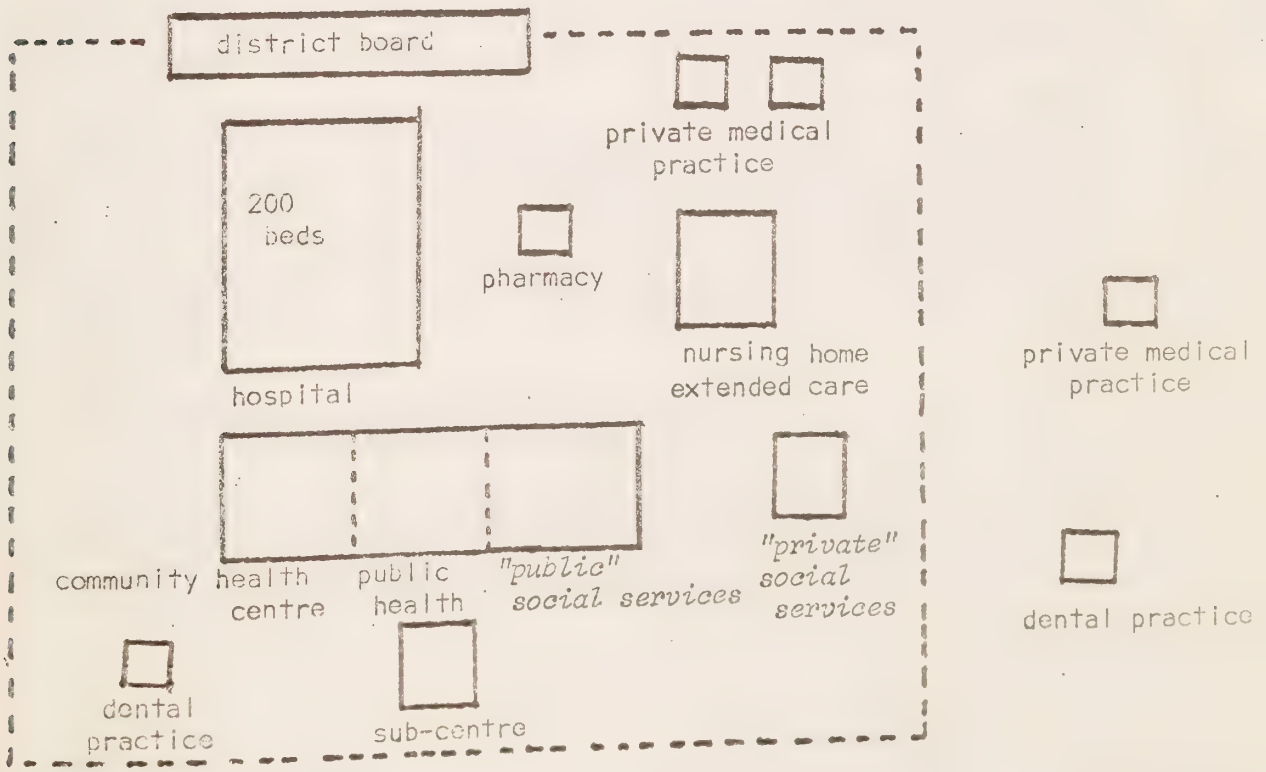
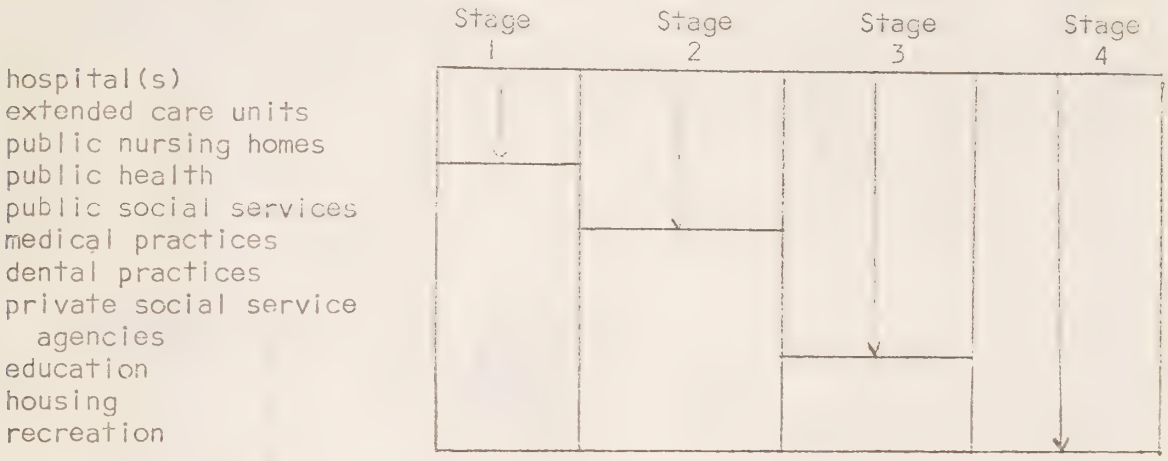


Diagram 1

The implementation of the district health and social services program might be staged in the following way:



2. RURAL HEALTH SERVICES SYSTEM

Diagram 2 shows a rural area with a principal town of 8,000 people, 2 medical groups, several pharmacies, a 70 bed local hospital and a mental health centre. There are several outlying villages, some with local hospitals, and a reserve. The physicians in the medical group refer to the university hospital rather than the regional hospital (located in the district centre - 250,000 people) because they fear losing patients to mixed general practice - specialist groups in the district centre.

In Diagram 3, one of the medical groups, the mental health centre and a pharmacy decide to form a community health centre. The province closes the small local hospitals and establishes sub-centres. In some cases, the hospital buildings might be converted into sub-centres (or even a full centre) and day-care centres or facilities for handicapped children. Because the income of the physicians in the health centre cannot be jeopardized they refer to the secondary level hospital at the district centre.

The procedure for changing a local hospital into a community health centre or sub-centre can be briefly outlined.

In the diagram, the hospital in the community of 1,000 (for example) serves a large, well-defined rural catchment area. The hospital has 10 beds, an out-patient department, 2 physicians, 4 registered nurses, a secretary-administrator and a maintenance staff. Since the hospital operates

BEFORE

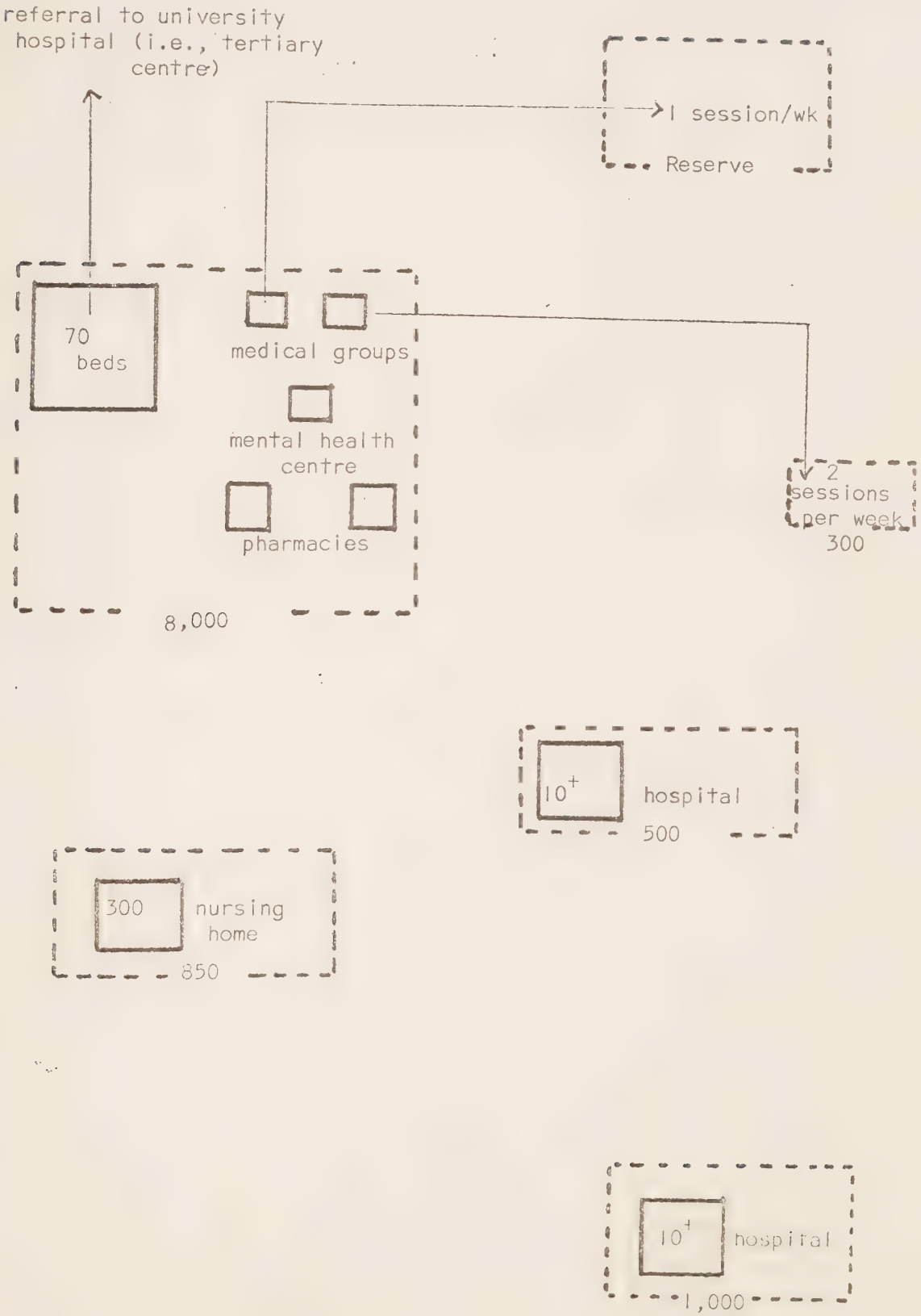


Diagram 2

AFTER

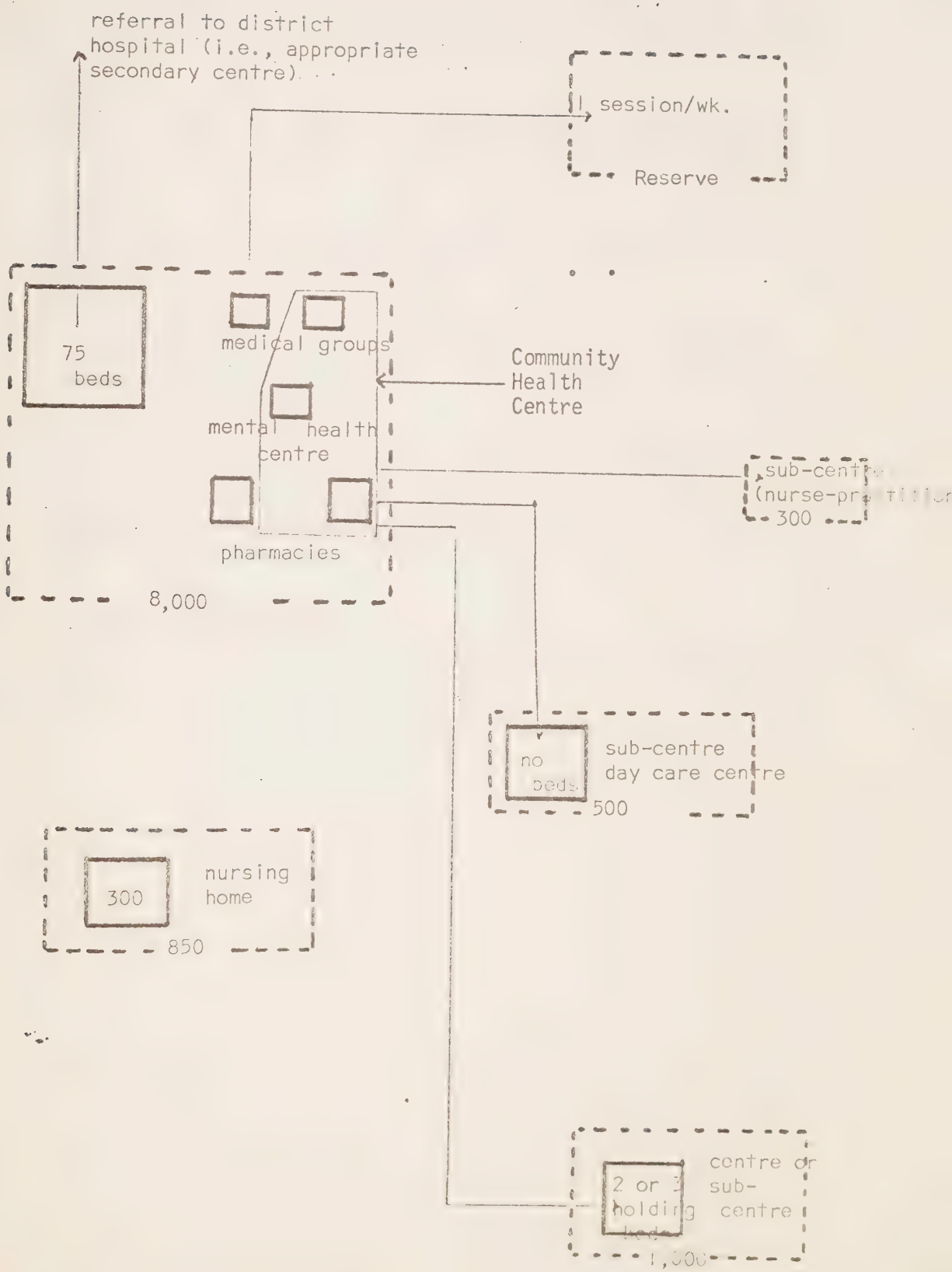


Diagram 3

under the Health Insurance and Diagnostic Act, there is little incentive to establish a home care program in the community and catchment area, a mental health program, or to assure effective community input. The hospital should be converted to a health centre by the following steps:

1. Discontinue in-patient activity
2. Develop a more comprehensive range of ambulatory care services. Include: home care, preventive programs, mental health program.
3. Run an orientation program for all staff, trustees, and the public.
4. Expand the health care team by adding, for example, a nutritionist, public health nurses, social workers.
5. Evaluate the new program
   (a) develop a records system capable of providing a basis for evaluation
   (b) develop appropriate evaluative skills backed up by provincial or district personnel.
6. Consider mechanisms of effective consumer involvement, e.g. community health association.
7. Integrate the centre into the health care system. This requires an organizational response at the district or area level (i.e., an area health board).

3. A COMMUNITY HEALTH CENTRE

Diagram 4 gives an outline view of a possible community health centre.

A POSSIBLE COMMUNITY HEALTH CENTRE

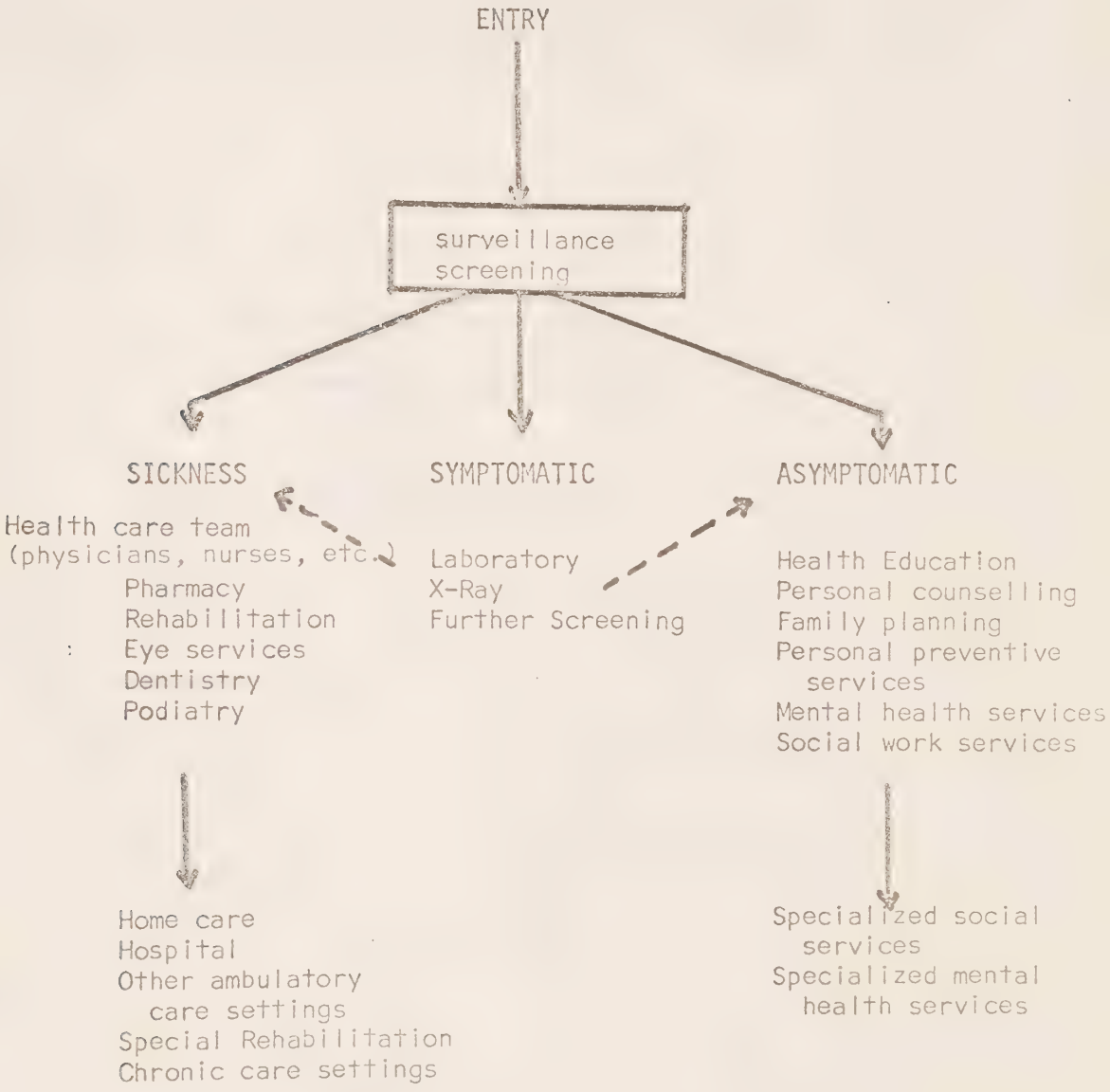


Diagram 4

4. COMBINED CENTRE

The "single unit" centre to provide both health and social services consists of 3 basic components, reception, health services, social services (Diagram 5). Such units might serve 30-40,000 people in an urban setting, 10-20,000 in a rural setting

SINGLE UNIT CENTRE

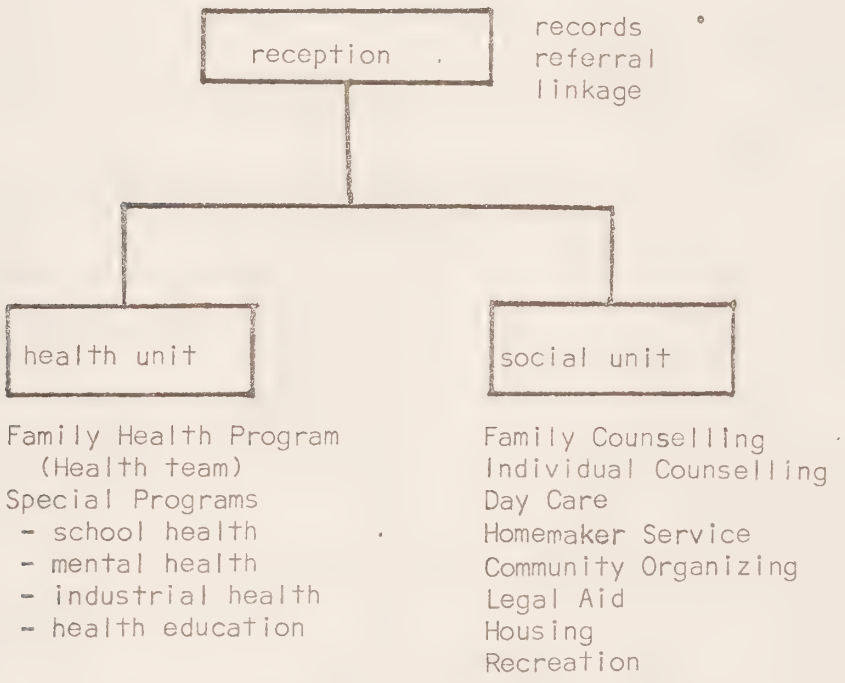


Diagram 5

APPENDIX C

1. COMMISSIONED PAPERS
2. BRIEFS
3. VISITS
4. SEMINARS

1. COMMISSIONED PAPERS

Title	Author
Community Health Centres: Health Care Organizations of the Future?	Anne Crichton, Vancouver
Economic Characteristics of Community Health Centres: Summary and Conclusions.	A. Peter Ruderman, Toronto
The Distribution of Available Health Care Personnel and Health Resources in Canada	Stanley Greenhill, Edmonton
Unmet Medical Needs	W.H. leRiche, Toronto
Health Maintenance Organizations	R.J.C. Pearson, Ottawa
The Costs of Screening for Disease	R.J.C. Pearson, Ottawa
Current Patterns of Primary Health Care Delivery	R. Steele, Kingston
The Health Care of Children in the 1970's and Beyond	H. Moghadam, Toronto
The Role of the Obstetrician	F.E. Bryans, Toronto
The Future Role of the Internist	W.B. Spaulding, Hamilton
The Role of the Psychiatrist in Primary Health Care	Donald B. Coates, Vancouver
Problèmes de définition et d'adaptation	Jean-Pierre Alix, Sherbrooke
Some Thoughts on the Community in Community Health Centres	Norman Bell, Toronto
The Feasibility of Implementing the Community Health Centre Concept	David Fish, Winnipeg
Citizen Participation in the Community Health Centre: Consumer Restraints upon the Emergence of New Forms of Ambulatory Care	Jean L. Elliott, Halifax

Case Studies Summary	Peter New, Toronto
University Settlement House	Ursula Anderson, Toronto
The Niagara Clinic, Toronto	Ursula Anderson, Toronto
Resume of Information on Community Health Centres of the Hospital for Sick Children	Ursula Anderson, Toronto
Halifax North End Community Health Clinic, Nova Scotia	Jean L. Elliott, Halifax
Supplementary Report, North End Community Clinic, February 8, 1972	Jean L. Elliott, Halifax
Second Supplementary Report, North End Health Clinic, February 8, 1972	Jean L. Elliott, Halifax
University of Manitoba Northern Medical Unit, Churchill, Manitoba	D.G. Fish, Winnipeg
Mount Carmel Clinic, Winnipeg, Manitoba	D.G. Fish, Manitoba
The Blackhead Road Health Center, St. John's Newfoundland	L.W. Gerson, St. John's
Student Health Service, Memorial University Newfoundland, St. John's Newfoundland.	L.W. Gerson, St. John's
International Grenfell Association, St. Anthony, Newfoundland	L.W. Gerson, St. John's
Description des centres communautaires de santé dans le Québec: (1) Le centre de Grande-Vallée (2) Le C.L.S.C. d'Hochelaga-Maisonneuve (3) La clinique St. Jacques	Claude Gousse, Montreal
Morley Reserve Health Centre	Patricia E. Kariel,Calgary
Ottawa and District Community Health Centre Foundation	Maureen M. Law, Toronto
North Preston Clinic, Nova Scotia: A Case Study	John A. MacKenzie

Two Views of Community Health Centres (British Columbia)	Roger S. Tonkin, Vancouver George Szasz, Vancouver
Community Clinics in Saskatchewan	Morton Warner, Vancouver
The Reach Centre, Vancouver	Morton Warner, Vancouver
Medical Services in Company Towns Pinawa Hospital, (British Columbia)	J.L. Weeks, Pinawa
St. Catherines Community Health Centre Foundation	
The Relationship of Emergency Services and Community Health Centres: One Perspective	Peter New, Toronto
Implementation for a Community Health Centre Program	Thomas Philbrook, Toronto
Community Health Centres: Comments on Organization	V.L. Matthews, Saskatoon
The Canadian Health Scene: Political Reality	Lloyd Detwiller, Vancouver
Health Care Delivery: Physician Attitudes	R.G. Wilson, Vancouver
Education of Personnel for Primary Health Care	Donald E. Larsen, Calgary
Consumer Education and Re-education and New Forms of Health Care Delivery	Morton, Warner, Vancouver
The Community Health Centre-Organizational Aspects	John H. Babson, Ottawa D.L. Martin, Ottawa D.V. Nightingale, Ottawa R.W. Sutherland, Ottawa
The Influence of the Drug Industry in Canada's Health System	George M. Torrance, Toronto
Existing Systems of Pharmaceutical Services: The Drug Distribution System	John A. Bachynsky, Ottawa
Some Observations on Methods of Physician Remuneration in Canada	R.A. Armstrong, Ottawa

The Measurement and Improvement of Quality in Ambulatory Health Care	Carol Buck, London, Ont.
How Can the Quality of Ambulatory Care be Improved?	Michael Draper, Sherbrooke
Evaluation of Innovative Community Ambulatory Care Programs During Periods of Social Change	David Sackett, Hamilton
Medical Records in Community Health Centres	Robert Morgan, Toronto
Health Centres: an International Comparison of Trends and Issues	Robin F. Badgley, Toronto
A Report on Economies in Group Practice Prepared for the Community Health Centre Project	R.G. Beck, Saskatoon
Accountancy and Related Aspects of Group Practice	W.T.T. Davison, Windsor
Medical Productivity and Group Practice	R.G. Evans, Vancouver
Community Health Centres and the Cost of Acute Hospitalization in Canada	R.G. Evans, Vancouver
The Impact of Health Centres on Patterns of Hospital Expenditures	R.G. Evans, Vancouver
A Study of Alberta Health Care Insurance Commission on Payments to Alberta Doctors by Size and Organization of Practice	D.F. Haythorne, Edmonton
Medical Care Utilization under Two Systems of Payment	Hans Kieferle, Winnipeg
Centralization of Services	G. Kerle Palin, Toronto
Some Comparisons of Group Practices from an Economic Viewpoint	G. McCracken, Toronto
Surveillance Methodology	T. Owen, Ottawa

Community Health Centres: Manpower Considerations	George P. Evans, Ottawa
Ambulatory Health Care: The Views of a Clinic Physician	Neville H. Smith, Regina
Nursing: Community-Related Personnel, Attitudes and Projects	Dorothy J.Kergin, Hamilton
Allied Health Personnel in Community Health Centres	Oswald Hall, Toronto
Background Paper: Pharmaceutical Services	John A. Bachynsky, Ottawa
The Dentist, Dental Practice and the Community Health Centre	Bruce A. McFarland, Ottawa Angus E. Reid, Ottawa
Social Work Practice in Community Health Centres	Len Ghan, Regina
Paper Prepared for Seminar on Hospital Administration	F.H. Griffith, Sault Ste. Marie
Some Administrative Problems and Experiences of a Business Manager in a Regional Multi-Specialty Clinic Part I - External Affairs Part II - Internal Affairs	Malcolm I. Chase, Regina
Public Health and Community Health Centres	C.W.Schwenger, Toronto
Mental Health Aspects of Primary Health Care	Donald B. Coates, Vancouver
The Relationship of Hospitals to Community Health Facilities	F. Burns Roth, Toronto
Social Service Delivery Systems	F.R. MacKinnon, Halifax
Difficulties and Advantages of Amalgamation	Graham J. Clarkson, Edmonton
Social Policies	A.Crichton, Vancouver
Citizen Involvement in Health Affairs	James Haughton, Chicago
Citizenship Involvement	A. Crichton, Vancouver

Citizen Involvement in Community Clinics	S. Rands, Regina L.G. Crossman, Regina
The Difficulties of Establishing a Community Health Centre	David A. Road, Regina
The Role of the Trade Union at the Regina Community Health Clinic.	Dorothy M. Lee, Regina
Problems of Attracting Personnel, Raising Capital, Referral to Outside Services, and Relationship with Non-Physician Health Professionals	J.D. Bury, Saskatoon
Development of an Optometry and Optical Dispensing Service at the Saskatoon Community Clinic	J.D. Bury, Saskatoon C.W. Hutton, Saskatoon D. La Pointe, Saskatoon
The Role of the Board and Clinic to Voluntary Groups: Community Health Services (Saskatoon) Association Limited	Betsy, Naylor, Saskatoon
Development of a Formulary Drug Prescription Program at the Saskatoon Community Clinic	J.D. Bury, Saskatoon S.R. Rice, Saskatoon
Resources, Priorities and Planning in the British National Health Service	Rudolf Klein, London, England
Notes towards a Theory of Patient Involvement	Rudolf Klein, London, England
The United States' Experience	Robert Kohn, Baltimore, U.S.A. Susan Radius, Baltimore, U.S.A.
Reflections from the United Kingdom and Western Europe to the Canadian Proposals for Community Health Centres	Robert L. Logan and Colleagues London, England
The Health Care System in Finland--Description of Non-Quantifiable Aspects	S. Häro, Helsinki, Finland

Seminar Summaries

Physicians' Services	Stanley Greenhill, Edmonton
Nursing Services	Verne H. Splane, Ottawa
Services of Allied Health Personnel	Anne Crichton, Vancouver
Pharmacy Services	J.N. Hlynka, Vancouver
Dental Services	A. Murray Hunt, Toronto
Social Work Services	John A. MacKenzie, Halifax
Administrative and Managerial Services	Anne Crichton, Vancouver
Personnel Seminars Summary	Anne Crichton, Vancouver
Public Health Services	Julien Denhez, Sherbrooke
Hospital Services	G.B. Rosenfeld, Ottawa
Mental Health Services	G.A. Ives, Toronto
Legal Aspects	J. Craig Patterson, Windsor, Ontario
Social Policy and Social Services	J.S. Morgan, Philadelphia, U.S.A.
Citizen Involvement	Anne Crichton, Vancouver
Joint Seminar on Design Aspects	T. Ogrodnik, Ottawa
Cost and Financial Aspects	A.P. Ruderman, Toronto

Reviewers

Dr. D.O. Anderson, Vancouver

Prof. D. Hewitt, Toronto

Dr. Robert Kohn, Baltimore

Dr. J. Wendell MacLeod, Ottawa

Dr. F.D. Mott, Toronto

Dr. J. Reid, Calgary

Dr. M. Roemer, Berkley

Dr. Malcolm Taylor, Toronto

2. BRIEFS

A. Organizational Submissions and/or other Communications

Consumers' Association of Canada
Imperial Order Daughters of the Empire
Federated Women's Institutes of Canada
Canadian Federation of Agriculture
Co-operative Union of Canada
Canadian Federation of University Women (13 separate branch submissions)
United Maritime Fishermen Ltd., Moncton
Canadian Labour Congress
Canadian Council on Social Development
Canadian Mental Health Association
London and District Community Health Foundation
Ottawa and District Community Health Foundation
The Canadian Federation of Business and Professional Women's Clubs
New Brunswick Labour Federation
Ontario Labour Federation
British Columbia Labour Federation
Manitoba Indian Brotherhood
Social Planning and Review Council of British Columbia (SPARC)
Co-operative Development Association, Regina
Saskatchewan Co-operative Credit Society Ltd., Regina
Newfoundland Co-operative Services, St. John's
Windsor Ostomy Club
Windsor and District Branch, The Canadian Diabetic Association
Health Centre Committee, Windsor and District Labour Council
A.W. Cluff and P.J. Cluff, Architects, Toronto
The Pastoral Institute of British Columbia
Prince Albert Co-operative Health Association
Canadian Medical Association
Nova Scotia Medical Association
Manitoba Medical Association
Newfoundland Medical Association

Saskatchewan Medical Association
Alberta Medical Association
British Columbia Medical Association
College of Family Physicians of Canada
Federation des Medecins Omnipraticiens du Quebec
Collège des Medecins et Chirurgiens de la Province de Quebec
Royal College of Physicians and Surgeons of Canada
College of Physicians and Surgeons of Manitoba
Dalhousie University, Faculty of Medicine
McMaster University, Faculty of Medicine
University of Calgary, Faculty of Medicine
Vice-President, Health Sciences, Dalhousie University
Vice-President, Health Sciences, University of Toronto
Dalhousie University, Director of Continuing Medical Education
University of Toronto, Department of Paediatrics
University of Toronto, Department of Community Medicine
University of British Columbia, Department of Community Medicine
Canadian Psychiatric Association
Canadian Opthalmological Society
Section of Opthalmology, Ontario Medical Association
Canadian Association of Radiologists
Association of Registered Nurses of Newfoundland
Nova Scotia Association of Registered Nurses
New Brunswick Association of Registered Nurses
L'Association des Infirmieres et Infirmiers de la Province de Québec
Manitoba Association of Registered Nurses
Saskatchewan Registered Nurses' Association
Alberta Association of Registered Nurses
Dalhousie University, Faculty of Nursing
University of New Brunswick, Faculty of Nursing
University of Toronto, Faculty of Nursing
University of Windsor, Faculty of Nursing
McGill University, Faculty of Nursing

University of British Columbia, Faculty of Nursing
Canadian Nurses Association
Victorian Order of Nurses for Canada (composite brief)
Canadian Dietetic Association
Canadian Association of Radiologists
Canadian Association of Medical Record Librarians
Canadian Association of Occupational Therapists (3 branches)
Canadian Physiotherapy Association
Canadian Chiropractic Association
Canadian Speech and Hearing Association;
  Atlantic Provinces Speech and Hearing Association
  Speech and Hearing Association of Alberta
  Saskatchewan Speech and Hearing Association
  Manitoba Speech and Hearing Association
Canadian Association of Optometrists
University of Waterloo, School of Optometry
Canadian Health Education Specialists Society
College of Family and Consumer Studies, University of Guelph
Household Science Alumnae, University of Toronto
University of Toronto, Faculty of Pharmacy
Pharmaceutical Association of the Province of British Columbia
British Columbia Professional Pharmacists Society
Canadian Dental Association
College de Chirurgiens Dentistes de la Province de Quebec
Canadian Society of Public Health Dentists
University of Toronto, Faculty of Dentistry
University of Alberta, Faculty of Dentistry
Pharmaceutical Manufacturers Association of Canada
Canadian Dental Hygienists Association
Mount Royal Dental Society Montreal
Montreal Dental Club, Inc.
Assiniboine Dental Group, Winnipeg
Canadian Association of Social Workers
University of Toronto, School of Social Work

Canadian Public Health Association

Association of Nursing Directors and Supervisors of Official Ontario Health Agencies

New Brunswick Department of Health

Ontario Department of Health, Local Health Services Branch (6 separate submissions)

Alberta Department of Health and Social Development

Ontario Association of Medical Clinics

Clinique Familiale St-Vincent, Sherbrooke

McGregor Clinic, Hamilton

Fort Frances Clinic, Fort Frances

Oshawa Clinic, Oshawa

Glazier Medical Centre, Oshawa

Grandview Medical Centre, Galt

Community Clinic, New Hamburg

Toronto Rehabilitation Centre

Assiniboine Clinic, Winnipeg

Regina Community Health Clinic

Prince Albert Community Clinic

Saskatoon Community Clinic

Medical Arts Clinic, Regina

The High Prairie Clinic, High Prairie

Irving Clinic, Kamloops

University Centre for Health Sciences, University of Wisconsin

The Lower Mainland Preventative Medical Centre, Ltd., Vancouver

Herzel Health Centre, Montreal

Clinical Investigation Unit, Hospital for Sick Children, Toronto

Selkirk Health Team of Manitoba, Selkirk

Haelen Industries Ltd., Don Mills, Ontario

Interlake Development Corporation, Inc., Arborg, Manitoba

B. Individual Submissions and/or Communications

J.C. Johnson, M.D., Dalhousie University

Lea C. Steeves, M.D., Dalhousie University

N.S. Jamieson, M.D., Moosomin, Saskatchewan

de Guise Vaillancourt, M.D., University of Montreal

I.R. McWhinney, M.D., University of Western Ontario

Gertrude Sleeva, M.D., Toronto

J.G. Mills, M.D., Calgary General Hospital

Medical Management Services, Calgary

W.S. Hunter, M.D., Toronto

Mrs. B. Cochrane, Ontario

Miss Peggy Witt, Ontario

Miss J. Parker, Saskatchewan

Miss A.J. Lawrence, Alberta

Mrs. W. Evans, Alberta

Miss S. Herel, British Columbia

Mrs. J. Reddick, R.N., Trenton Memorial Hospital, Ontario

Mrs. J. Cochrane, R.N., Hamilton

Mrs. L. McClure, R.N., Winnipeg General Hospital

Mrs. C. Hotel, R.N., Nananmo, British Columbia

Mrs. Joy Calkin, University of Wisconsin

Miss B. Chadwick, Physiotherapy Services, Hamilton

Mr. M.E. Trotman, Member, Canadian Society of Physiotherapists, Cornwall, Ontario

Mrs. Vera Barry, Psychologist, Alberta Guidance Clinic, Red Deer

Mr. N.M. Lillos, D.O.S., Secretary-Treasurer, Board of Examiners in Optometry, New Westminster

Merrium Clancy and Naomi Page (submission on Homemaker Services)

Dr. Z.I. Sabry, National Co-ordination, Nutrition Canada, Ottawa

Dyck's Drugs, Ltd., Kelowna

Mr. A.C. Scales, Phm.B., Hamilton

R.A. Connor, D.D.S., Dalhousie University, Department of Paediatrics and Community Medicine

G.M. Dundass, D.D.S., Montreal

E. Kaellis, D.D.S., Victoria

A.S. Gray, D.D.S., Regional Dental Consultant, South Okanagan Health Unit, Kelowna

J.H. Corsbie, C.U.&.C., Health Services Society, Vancouver

F.D. Mott, M.D., School of Hygiene, University of Toronto
Sister M. Liguori, Director, Pharmaceutical Services, St. Michael's Hospital
A.G. Foulkes, M.D., Royal Columbian Hospital, New Westminster
Director of Nursing, Etobicoke General Hospital
S.E. Middleton, Administrator, Louise Marshall Hospital, Mount Forest, Ontario
Charles Grierson, Greater Vancouver Regional Hospital District
Professor C. McNiven, School of Social Work, University of British Columbia
A.D. Kelly, M.D., Canadian Red Cross Society
M. Jules Boudreault, Montreal
Mrs. R. Pais, Montreal
Mr. S.R. Day, Ottawa
Mrs. D. Thompson, Dundas, Ontario
Mrs. B. Baillie, Burlington
Mrs. H. Willcox, Bridgenorth, Ontario
Mr. Jim Richards
Mrs. P.L. Day, Ontario
Mrs. Le Dunn, Oakville
Mrs. R.S. Mills, Toronto
Mr. D.E. Beattie, London
Mrs. H.A. Wansbrough, Arthur, Ontario
Mr. P. Lazarenko, Edmonton
Professor Stanley A. Perkins, Ed.D., University of Lethbridge
Miss E.C. Black, Vancouver
Mrs. H.B. Bodley, Toronto
Mrs. C.G. Halsey, R.N., Okanagan Mission, British Columbia
Rev. D. Charles H. Forsyth, St. Andrew's Church, Sudbury
L.C. Bartlett, M.D., Winnipeg
R.L. DeMers, Toronto
J.R. Greenaway, M.D., Amherstburg
J.R. Jones, M.D., Windsor
H. Grandy, Mayor, Garnish, Newfoundland

C. Foreign Communications

World Health Organization, Geneva
World Health Organization, Copenhagen

W.H.O. - Pan American Health Organization, Washington

British Ministry of Health and Social Security

Scottish Home and Health Department

Professor Ragnar Berfenstam, Uppsala, Sweden

Association of University Programs in Hospital Administration, Washington

Professor Alan Blackman, School of Public Health, University of Michigan

Dr. Ron Carlson, Director, Special Operations Bureau, Health Insurance, Baltimore

United States Department of Health Education and Welfare

American Association of Medical Clinics

Group Health Association of America

3. VISITS AND DISCUSSIONS (other than with Committee members and those participating in seminars)

Canada

Hon. John Munro, Minister of National Health and Welfare

Deputy Minister of National Health

Consultation with seminar members of the Health Programs Branch, Medical Services Branch, Long Range Planning Directorate, Health Statistics Branch, and Non-Medical Use of Drugs Directorate and former Health Services Directorate

Canadian Medical Association

Canadian Nurses' Association

Canadian Pharmaceutical Association

The Association of Canadian Medical Colleges

College of Family Physicians of Canada

Canadian Council on Social Development

National Indian Brotherhood

Pharmaceutical Manufacturers Association of Canada

Science Council of Canada - Health Sciences Study Director and group

The Royal College of Physicians and Surgeons of Canada

The Canadian Hospital Association

The Canadian Public Health Association

Victorian Order of Nurses of Canada

Canadian Council on Hospital Accreditation

Canadian Dental Association

Canadian Clinic Managers Association

Canadian Opthalmological Association

Canadian Psychiatric Association

Individual Members, Canadian Chapter, American College of Hospital Administrators

Canadian Association of Medical Clinics

Newfoundland and Labrador

Hon. Dr. A.T. Rowe, Minister of Health

Chairman and Secretary, Newfoundland and Labrador Health Council

Deputy Minister of Health

Assistant Deputy Minister, Department of Social Services and Rehabilitation

Chairman and Medical Director, The Newfoundland Medical Care Commission

President and Executive Director, The Newfoundland Hospital Association

President and Past President, Newfoundland Medical Association

President and Committee on Community Health Centre Project

The Association of Registered Nurses of Newfoundland

Members of Faculties of Medicine and Nursing, Memorial University

Members of Division of Community Medicine, Memorial University

Executive and local Members, Canadian Public Health Association, Newfoundland and Labrador Branch

Representatives of St. John's Hospital Advisory Council

New Brunswick

Hon. P.S. Creaghan, Minister of Health

Hon. Mrs. Brenda Robertson, Minister of Welfare

Chairman, Health Services Advisory Council

Senior officials of the New Brunswick Department of Health in hospital services, medicare, public health, administration and financial services, laboratory, mental health, public health nursing, research and planning and personal health services

President, New Brunswick Medical Society

Assistant Administrator, Saint John General Hospital

Fredericton Medical Clinic

Nova Scotia

Hon. Scott MacNutt, Minister of Public Health

Hon. Allen E. Sullivan, Minister of Public Welfare

Chairman, and Executive members, Nova Scotia Council of Health

Deputy Minister of Public Welfare and senior personnel

Administrator, Health Unit Services and other senior officials of the Nova Scotia Department Public Health in public health, dental, public health nursing, occupational health divisions.

Citizen members, the administrator and professional staff volunteers of the North End Clinic

Professional staff volunteers of the North Preston Clinic

Dartmouth Medical Centre

Dartmouth Emergency Hospital

Wolfville Mental Health Clinic

Annapolis Valley Health Unit

Cape Breton South Health Unit

Vice-President, Health Sciences, Dalhousie University

Associate Dean, Faculty of Medicine, Dalhousie University

Chairman, Department of Preventive Medicine, Dalhousie University

The Nova Scotia Sanatorium

President, The Medical Society of Nova Scotia

The Committee of the Cape Breton Regional Health Planning Project - some 100 people

Staff members, Health Policy Group, Greater Halifax Social Planning Council

Prince Edward Island

Hon. Dr. J.H. Maloney, Minister of Health and Welfare

Deputy Minister of Health

Deputy Minister of Welfare

Chairman, Health Services Commission and senior officials

Chairman, Hospital Commission and senior officials

Senior officials of the Prince Edward Island Departments of Health and of Welfare in public health, public health nursing, home care, child welfare.

President and executive member, Prince Edward Island Medical Association

Québec

Hon. Claude Castonguay, Ministre des Affaires Sociales

Sous-Ministre des Affaires Sociales

Plusieurs hauts fonctionaires de Ministère des Affaires Sociales et de la Direction Generale de la Programmation

Directeur de la Division Dentaire, Service de la Médecine Préventive

Group meeting with representatives of:

Association Médicale de la Province de Québec

Association des Médecins de la Langue Française du Canada

Fédération des Médecins Omnipraticiens

Fédération des Médecins Spécialistes

Collège des Médecins et Chirurgiens de la Province de Québec

Association des Hôpitaux de la Province de Québec

Association des Infirmières de la Province de Québec

Collège des Optométristes de la Province de Québec

Collège des Chirurgiens Dentistes de la Province de Québec

Association Québécoise des Pharmaciens Propriétaires

Société de Services Sociaux aux Familles

Group meetings with representatives of:

Les facultés de la Santé et le département de Service Social, Université de Montréal

Les facultés de la Santé, Université McGill

Les facultés de la Santé, d'Administration des Affaires et de Service Social, Université Laval

Faculté de Médecine, Université de Sherbrooke

Département de Médecine Sociale et Preventive, Université Laval

Division de Médecine Sociale, Departement de Médecine Communautaire, des Sciences du Comportement et d'Epidémiologie, et le Departement de Service Social, Université de Sherbrooke

Le Comité de Planification des Cantons de l'Est

C.L.S.C. Hochelaga-Maisonneuve, Montréal

Clinique Pointe Ste. Charles, Montréal

Président, du Conseil de'Administration, Domus Medicus, Montreal

Fédération du Conseil Régional de Bien Etre, Sherbrooke

Directeur des Services de Soins à Domicile, Sherbrooke

Coordinateur Régional, Ministère des Affaires Sociales, Sherbrooke

Centre de Référence et d'Information, Sherbrooke

Ontario

Hon. A.B.R. Lawrence, Minister of Health (to February, 1972)

Social Policy Planning Committee of Cabinet (after March, 1972)

Hon. R. Welch, Provincial Secretary for social policy

Hon. R. Potter, Minister of Health

Hon. R. Brunelle, Minister of Social and Family Services

Hon. T. Wells, Minister of Universities and Colleges

Deputy Minister, Social Policy

Deputy Minister of Health

Chairman, Ontario Health Services Commission

Chairman, Ontario Council of Health

Senior Consultant, Social and Family Services

Senior health department officials in public health division, (regional medical officers and other personnel, public health dentistry, public health nursing, underserviced areas, public health education, laboratory services), research and planning, medical services plan research, hospital services plan research

One day seminar-meeting with some 72 representatives of Health Sciences Faculties of Ontario:

University of Toronto

University of Western Ontario

Queen's University

Ottawa University

McMaster University

University of Windsor

Waterloo University

Director and senior staff in health administration, School of Hygiene, University of Toronto

Behavioural Sciences Department, University of Toronto

Chairman, Department of Community Medicine, University of Toronto

Ontario Medical Association

Ontario Association of Medical Clinics

Manitoba

Health, Education and Social Planning Committee of Cabinet:

Hon. S. Miller, Chairman

Hon. R. Toupin, Minister of Health and Social Development

Hon. B. Hanuschuk, Minister of Education

Hon. R. McBryde, Minister without Portfolio

Deputy Ministers of Health and Social Development, Colleges and Education

Secretary, Management Committee of Cabinet

Chairman, members and senior officials of Manitoba Health Services Commission

Dr. Cecil Sheps and Mr. G.W. Kushner, Q.C. -- special consultants to Government of Manitoba on health care questions

Dean, Faculty of Medicine and senior colleagues

Director, University Hospital, Chief of Staff and other colleagues

Registrar and Associate Registrar, College of Physicians and Surgeons of Manitoba

President and Executive, C.M.A., Manitoba Division

Winnipeg Clinic; Executive Committee

Assiniboine Clinic; Administrator, medical staff, dental staff

Grace Hospital; Medical Director, psychiatric unit

Selkirk Area Health Team

Mt. Carmel Clinic; Director and Medical Staff Chief

Special Committee of Manitoba Association of Registered Nurses (representing public health, hospital, V.O.N. and nurse clinical assistant interests)

Winnipeg Children's Hospital community outreach; Dr. Percy Barsky

Manitoba Indian Brotherhood; Chief D. Courchene

Administrator and Medical Staff Chief, Deer Lodge Hospital

President and Executive Director, Community Welfare Planning Council of Winnipeg

Saskatchewan

Hon. W.E. Smishek, Minister of Public Health

Hon. G.I. Snyder, Minister of Welfare

Mr. J. Richards, Legislative Secretary, Minister of Public Health

Deputy Minister of Public Health and senior officials in public health, Saskatchewan Hospital Services Plan, research and planning

Senior officials of Medical Care Insurance Commission

Deputy Minister of Welfare

Executive Secretary, Federation of Labour

Regina Community Health Clinic

Medical Arts Clinic, Regina

President and Executive, Regina and District Medical Society

Registrar, College of Physicians and Surgeons of Saskatchewan

Executive Secretary and several officers, Saskatchewan Medical Association

Dean, Faculty of Medicine, members - Departments of Social and Preventive Medicine, Family Practice, and of Rehabilitation Medicine.

Secretary, Saskatoon and District Medical Society

Saskatoon Community Clinic

Prince Albert Community Clinic

Alberta

Hon. Neil Crawford, Minister of Health and Social Development

Senior Deputy Minister of Health and Social Development

Deputy Minister of Health

Deputy Minister of Services

Dr. J.G. Clarkson, Consultant, Department of Health and Social Development

Senior officials, Alberta Hospital Services Commission

Chairman and senior officials, Alberta Health Care Insurance Commission

Head of Psychiatric Services

Administrator, High Level Project

Associate Dean, Faculty of Medicine, University of Alberta, Edmonton

Selected members, Departments of Social and Community Medicine, Surgery Family Practice, Medicine and Health Services Administration

Executive Director, University Hospital, Edmonton

President and Executive, Alberta Medical Association

Two Regional Medical Officers of Health

President and Executive, Alberta Hospital Association

Special Committee, Alberta Association of Registered Nurses (representing university, public health, hospital, V.O.N interests)

Dean and senior faculty in community medicine, paediatrics,medical sociology, family practice, ambulatory care, University of Calgary, Faculty of Medicine,

Calgary Area Hospital Administrators and officials of Calgary Area Hospital Planning Council

British Columbia

Hon. R.A. Loffmark, Minister of Health Services and Hospital Insurance

Deputy Ministers of Public Health, Hospital Insurance and Mental Health Services and other senior officials in the three branches

Chairman, Hospital Insurance Commission and senior officials

Director, Medicare Plan

Meeting with 30 people(professional and citizen) interested in various community health and social service clinic programs from Vancouver interior and Vancouver Island

Reach Clinic

Meeting, under auspices of S.P.A.R.C. (Voluntary Health and Welfare Association of British Columbia) with 150 representatives of voluntary, professional, university, Indian , hospital and other citizen groups in health and welfare

Medical Health Officers, Metropolitan Health Services of Greater Victoria

Meeting with executives and other physicians (25 people) of British Columbia Medical Association and College of Physicians and Surgeons of British Columbia

Registered Nurses' Association of British Columbia

Deans, Faculty of Medicine

Director School of Social Work

Meeting with 25 representatives of health sciences, social faculties and Department of Economics, University of British Columbia

Consultant Administrator, University Hospital, University of British Columbia

Medical Director, Childrens' Aid Society of Vancouver

Representative of Community Council of Greater Victoria

Group from Physical Medicine Department, Vancouver General Hospital

Group from Centre for Environmental Health, Simon Fraser University

Other

Visiting group of senior government, university and hospital officials from Sweden, Professor A. Grönwal, Chairman

Professor Robert L. Logan and colleagues, London School of Hygiene and Tropical Medicine

Senior officials of British Ministry of Health and Social Security and of Scottish Home and Health Department

Other senior public health, medical, hospital,university and government personnel in the United Kingdom

Senior government, university, and professional association personnel in Belgium, Netherlands, France, Czechoslovakia

Professor Robert Kohn and colleagues, John Hopkins School of Public Health

Professor M. Roemer and Professor Carl Hopkins and colleagues, School of Public Health, University of California (Los Angeles)

Association of Teachers of Preventive Medicine of United States Western Region

Visits to selected United States service programs

Director and senior staff, World Health Organization - Pan American Health Organization, Washington, D.C.

Dr. Merle Cunningham, Rochester University

Dr. A. Adams, School of Public Health, Sydney, Australia

Mr. H. Beer, Sydney Hospital Executive Director

United States Department of Health, Education and Welfare

4. SEMINARS

Economic Seminar

Dr. John Aldis	Medical Services Insurance Division, Ontario Department of Health, 2195 Yonge St., Toronto 7.
Mr. John Allan	Assiniboine Clinic, 633 Lodge Ave., Winnipeg 12.
Dr. Robert Armstrong	Medical Care, Health Programs Branch, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. Glen Beck	Department of Economics, University of Saskatchewan, Saskatoon.
Prof. Richard Béland	Department of Behavioural Sciences, Faculty of Medicine, University of Sherbrooke, Sherbrooke.
Dr. Jack Boan	Department of Economics, University of Saskatchewan, Saskatoon.
Dr. W.F. Craig	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. W.T.T. Davison	c.a., 1666 Wyandotte St. E., Windsor
Dr. Robert G. Evans	Department of Economics, University of British Columbia, Vancouver.
Mr. Fred Griffith	Group Health Centre, 240 McNabb St., Sault Ste. Marie.
Dr. J.K. Hayes	P.O. Box 500, Halifax.
Mr. Donald Haythorne	Department of Community Medicine, Faculty of Medicine, University of Alberta.
Dr. David Kinloch	Ontario Medical Services Insurance Plan, Toronto
Dr. Duncan Macewan	Research and Planning Branch, Ontario Department of Health
Prof. George McCracken	Department of Health Administration, School of Hygiene, University of Toronto
Mr. Jim McMillan	Peterborough Clinic, 327 Charlotte St., Peterborough
Dr. Jean Yves Rivard	Department of Health Services Administration, University of Montreal, Montreal
Dr. A.P. Ruderman	Department of Health Administration, School of Hygiene, University of Toronto
Dr. J. Scotton	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. Hugh Walker	Management & Operations Research Unit, Ontario Health Services Commission, 2195 Yonge St., Toronto.

Attitude Seminar

M. Jean P. Alix	Comite de Planification des Cantons de l'Est, Centre Hospitalier Universitaire, Sherbrooke
Dr. Robin Badgley	Department of Behavioural Sciences, Faculty of Medicine, University of Toronto.
Mr. John Barker	15 Steven St., Sault Ste. Marie
Prof. Paul Bélanger	Department of Sociology, Universite Laval
Dr. Norman Bell	Department of Sociology, University of Toronto
Dr. Bernard Blishen	Graduate Studies, Trent University
Dr. W.F. Craig	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. Jean Elliot	Department of Sociology, Dalhousie University
Dr. David Fish	Medical Sociology, Faculty of Medicine, University of Manitoba, Winnipeg.
M. Claude Gousse	Montreal
Dr. Stanley E. Greenhill	Department of Community Medicine, Faculty of Medicine, University of Alberta, Edmonton.
Dr. Duncan Kippen	Winnipeg Clinic, Winnipeg.
Dr. Moris Kelley	National Welfare Grants, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Prof. P. Laporte	Department of Behavioural Sciences, Faculty of Medicine, Sherbrooke University.
Dr. Don E. Larsen	Division of Community Health Sciences, Faculty of Medicine, University of Calgary.
Dr. Vince L. Matthews	Department of Social & Preventive Medicine, Faculty of Medicine, University of Saskatchewan, Saskatoon.
Mr. John A. MacKenzie	Social Research & Planning, Department of Public Welfare, Halifax.
Prof. Tom Philbrook	Faculty of Environmental Studies, York University, Downsview, Ontario.
Mr. Morton Warner	Department of Health Care & Epidemiology, University of British Columbia, Vancouver.

Invited - Unable to Attend

Dr. D.O. Anderson	Division of Research & Development, Health Sciences Centre, University of British Columbia, Vancouver.
Dr. G. Briggs	Department of Sociology, University of Alberta, Edmonton.

Other Consultants

Dr. Frank Bach	Department of Social Work, University of Calgary
Dr. G. Briggs	Department of Sociology, University of Alberta, Edmonton.
Prof. David Coburn	Department of Behavioural Sciences, University of Toronto.
Dr. Elaine Cumming	Department of Sociology, University of Victoria
Dr, C. Nelson	Department of Community Medicine, University of Alberta, Edmonton.

Physicians Seminar

Dr. W.J. Copeman	Ontario Department of Health, Program for Under-serviced Areas, Toronto.
Dr. P. Delva	Centre Hospitalier Universitaire, Sherbrooke,
Dr. F.B. Fallis	College of Family Physicians of Canada
Dr. J. Garson	Saskatoon Community Clinic, Saskatchewan
Dr. Peter Gordon	Nova Scotia Health Council
Dr. Stanley E. Greenhill	Department of Community Medicine, Faculty of Medicine, University of Alberta, Edmonton.
Dr. Guy Hamel	Fédération des Médecins Omnipracticiens du Québec
Dr. Francois Hébert	Fédérations des Médecins Spécialistes du Québec
Miss Rose Imai	Canadian Nurses Association
Dr. L.B. Janz	British Columbia Medical Association
Dr. Neville H. Smith	Medical Arts Clinic, Regina
Dr. J.D. Wallace	Canadian Medical Association

Observers

Dr. Helen K. Mussalem	Canadian Nurses Association

Invited - Could not Attend

Mr. John Barker	15 Steven St., Sault Ste. Marie.
Dr. Louis Christ	Faculty of Medicine, University of Saskatchewan, Saskatoon.
Mr. Bruce McKenzie	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.

Nurses Seminar

Miss Patricia Edward	Winnipeg Clinic, Winnipeg
Dr. George Evans	Health Manpower Planning Division, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. Stanely E. Greenhill	Department of Community Medicine, Faculty of Medicine, University of Alberta, Edmonton.
Miss Rose Imai	Canadian Nurses' Association
Dr. Dorothy J. Kergin	School of Nusing, McMaster University, Hamilton
Miss Jean Leask	Victorian Order of Nurses for Canada
Miss Rita Lussier	Association of Nurses of the Province of Quebec
Mrs. Lyn McClure	Winnipeg General Hospital, Winnipeg
Dr. Helen Mussalem	Canadian Nurses' Association
Mrs. Verna H. Splane	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. Boyd Suttie	Division of Community Medicine, Faculty of Medicine, Memorial University, St. John's, Newfoundland
Dr. J.D. Wallace	Canadian Medical Association

Invited - Could not Attend

Miss V. Facey-Crowther	Outpatient Nursing Program, Memorial University, St. John's, Newfoundland
Miss Olivette Gareau	Ministry of Social Affairs, Quebec City
Dr. E. Tulchinsky	Department of Health & Social Development of Manitoba, Winnipeg.

Allied Health Personnel Seminar

Mr. John Crawford	Department of Social & Preventive Medicine, University of Saskatchewan, Saskatoon.
Dr. Anne Crichton	Research Co-ordinator, Community Health Centre Project.
Miss Patricia Edward	Division of Surgery, Winnipeg Clinic, Winnipeg
Mr. Lewis Edwards	Canadian Society of Radiological Technicians
Dr. Oswald Hall	Department of Sociology, University of Toronto
Mrs. Barbara Hylands	Canadian Dietetic Association

Mr. Donald Mandryk	The Canadian Speech & Hearing Association
Miss Mary Martin	Canadian Physiotherapy Association
Mrs. Janet Milner	Canadian Association of Medical Record Librarians
Miss E. Louise Miner	Canadian Nurses' Association
Mr. Pierre Parenteau	College des Optométristes de Québec
Mr. A. Shearer	Canadian Society of Laboratory Technicians
Miss Eleanor Sortome	Canadian Dietetic Association

Invited - Could not Attend

Mr. Reginald Adshead	Foothills General Hospital, Calgary.
Mr. Fred Griffith	Group Health Centre, Sault Ste. Marie
Mrs. Phyllis S. McFeat	Canadian Dietetic Association

Pharmacy Seminar

Dr. John A. Bachynsky	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. J. Corsbie	C.U.&.C. Health Services Society, Vancouver,
Dr. N.P. DaSylva	Canadian Medical Association
Mr. J. Dulude	Association Quebecoise des Pharmaciens Proprietaires.
Dr. J.N. Hlynka	Faculty of Pharmaceutical Sciences, University of British Columbia
Sister M. Liguori	Canadian Society of Hospital Pharmacists and Pharmaceutical Services, St. Michael's Hospital, Toronto.
Mr. S. Rice	Saskatoon Community Clinic, Saskatoon.
Mr. George Torrance	Department of Behavioural Science, University of Toronto.
Mr. J.C. Turnbull	Canadian Pharmaceutical Association
Dr. W.W. Wigle	Pharmaceutical Manufacturers Association of Canada
Mr. W.A. Wilkinson	Prescription Services Inc., Windsor

Invited - Could not Attend

Dr. John Aldis	Medical Services Insurance Division, Ontario Department of Health, 2195 Yonge St., Toronto.
Mr. Ralph Belyea	Corner Drug Co. Ltd.
Dr. W.F. Craig	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.

Dental Seminar

Dr. F.H. Compton	Canadian Dental Association
Mr. J. Corsbie	C.U.&.C. Health Services Society, Vancouver
Dr. P.E. Currie	Dental Services Council, Canadian Dental Association
Dr. R.M. Grainger	Association of Canadian Medical Colleges
Dr. A. Murray Hunt	Faculty of Dentistry, University of Toronto
Mrs. Patricia Johnson	Ontario Dental Hygienists' Association
Dr. W.C. King	Division of Dental Health, Department of Public Health, Nova Scotia.
Dr. Bruce A. McFarlane	Department of Sociology & Anthropology, Carleton University, Ottawa.
Dr. K.J. Paynter	Canadian Dental Association, Faculty of Dentistry, University of Saskatchewan,
Dr. Gilles Pelletier	Ministère des Affaires Sociales, Québec
Mr. Angus Reid	Department of Sociology & Anthropology, Carleton University, Ottawa.
Dr. W. Walker Shortill	Assiniboine Dental Group, Winnipeg
Mrs. Linda Zambolin	Canadian Dental Hygienists' Association.

Invited - Could not Attend

Dr. George Dundass	Collège des Chirurgiens Dentistes de la Province de Québec.

Social Workers Seminar

Mr. Len Ghan	Regina Community Health Clinic, Regina
Dr. Elizabeth Govan	School of Social Work, University of Toronto
Mr. Bruce MacKenzie	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. John A. MacKenzie	Department of Public Welfare, Halifax
Mr. John W. Murphy	The Fundy Mental Health Centre, Wolfville
Mr. Ross Reid	College of Family Physicians of Canada
Mrs. Genevieve Teed	Saskatoon Community Clinic, Saskatoon.
Mr. L. White	Canadian Association of Social Workers

Invited - Could not Attend

Dr. Jacques Alary	Département de Service Social, Université de Montréal.
Dr. Bruce Halliday	Tavistock, Ontario.
Dr. Andre Paul	Société de Service Social aux Familles

Managers & Administrators Seminar

Mr. J. Allan	Medical Group Management Association of Canada, Assiniboine Clinic, Winnipeg.
Mr. Malcolm I. Chase	Medical Arts Clinic, Regina
Mr. W.T.T. Davison	c.a., 1666 Wyandotte St. E., Windsor
Mr. Mel Derrick	Saskatchewan Department of Public Health, Regina
Mr. F.H. Griffith	Sault Ste. Marie & District Group Health Association, Sault Ste. Marie.
Mr. J.A. McMillan	The Peterborough Clinic, Peterborough
Dr. F. Burns Roth	Department of Health Administration, School of Hygiene, University of Toronto
Dr. A. Shardt	Canadian Association of Medical Clinics

Invited - Could not Attend

Mr. Raymond Lacroix	L'Association des Hôpitaux de la Province du Québec
Mr. Gaspard Massue	Association des Administrateur d'Hôpitaux du Québec

Public Health Seminar

Miss Dorothea Atkinson	Victorian Order of Nurses of Canada
Mr. John Barker	15 Steven St., Sault Ste. Marie
Dr. G.H. Bonham	Department of Health, Vancouver
Dr. B.T. Dale	Wellington-Dufferin-Guelph Health Unit, Ontario
Dr. Julien Denhez	Department of Community Medicine, University of Sherbrooke, Sherbrooke
Dr. Duncan Kippen	The Winnipeg Clinic, Winnipeg
Mrs. G.C. Lavallée	Canadian Public Health Association, Faculty of Nursing, University of Montreal
Dr. N.F. MacNeil	Cape Breton South Health Unit, Nova Scotia.

Dr. G.K. Martin	Ontario Department of Health, Toronto
Dr. Vince Matthews	Canadian Public Health Association, Department Social & Preventive Medicine, University of Saskatchewan, Saskatoon.
Dr. W.G. Meekison	Department of Health Care & Epidemiology, University of British Columbia.
Mr. Michael E. Palko	Department of National Health & Welfare, Health Education, Brooke Claxton Bldg., Ottawa.
Mme. Hélène Panalaks	Ministère des Affaires Sociales, Québec, Unité Sanitaire, Hull.
Dr. C.W. Schwenger	School of Hygiene, University of Toronto
Miss F. Tomlinson	Association of Nursing Directors and Supervisors of Ontario Official Health Agencies
Dr. T.H. Tulchinksy	Department of Health & Social Development of Manitoba, Winnipeg.

Mental Health Seminar

Dr. S. Appleton	Ontario Department of Health, Toronto.
Mr. Carl Birchard	Department of National Health & Welfare, Brooke Claxton Building, Ottawa.
Mrs. D. Burwell	Clark Institute of Psychiatry, Toronto.
Dr. Don E. Coates	Department of Psychiatry, University of British Columbia.
Dr. John Cumming	Mental Health Branch, Department of Health & Hospital Insurance, Parliament Bldgs., Victoria.
Dr. S.J.J. Freeman	Canadian Psychiatric Association, Clarke Institute of Psychiatry, Toronto.
Mr. C. Greenland	School of Social Work, McMaster University, Hamilton.
Dr. G.A. Ives	Psychiatric Services Branch, Ontario Department of Health, Toronto
Dr. Duncan Kippen	Winnipeg Clinic, Winnipeg.
Dr. Marcel Lemieux	Hamilton Psychiatric Hospital, Hamilton.
Mr. Len Levine	Department of Psychiatry, McMaster University, Hamilton.
Dr. John Macdonald	Canadian Mental Health Association, Council of Ontario Universities

Invited - Could not Attend

Dr. Craig M. Mooney	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.

Hospital Seminar

Mr. Reginald Adshead	Foothills Hospital, Calgary
Mr. Carl Birchard	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa
Dr. L.O. Bradley	Canadian Council on Hospital Accreditation
Dr. B.L.P. Brosseau	Canadian Hospital Association
Dr. Robert Evans	Department of Economics, University of British Columbia
Dr. Alan Finlay	Ambulatory Care Centre, Faculty of Medicine, University of Calgary
Dr. R.G. Foulkes	Royal Columbian Hospital, British Columbia
M. Raymond Lacroix	L'Association des Hôpitaux de la Province du Québec
M. Gaspard Massue	Association des Administrateurs de la Province de Québec
Dr. Peter New	Department of Behavioural Science, University of Toronto
Mr. G.B. Rosenfeld	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa
Dr. F. Burns Roth	School of Hygiene, University of Toronto

Social Services Seminar

Mr. R. Adshead	Foothills Hospital, Calgary
Dr. John Aldis	Ontario Health Services Commission, Ontario Department of Health, 2195 Yonge St. Toronto
Mr. John Barker	15 Steve St., Sault Ste. Marie
Ms. Novia Carter	Canadian Council on Social Development
Dr. Graham Clarkson	Faculty of Medicine, University of Alberta, Edmonton
Dr. Anne Crichton	Research Co-ordinator, Community Health Centre Project
Dr. L.F. Detwiller	University of British Columbia
Mrs. Davie Fulton	SPARC, Vancouver
Mlle. O. Gareau	Ministere des Affaires Sociales, Québec
Miss P. Godfrey	C.C.S.D., Ottawa
Mr. J.E. Green	Department of Welfare, Charlottetown
Dr. Bruce Halliday	College of Family Physicians of Canada

Mr. J.A. MacKenzie	Department of Public Welfare, Halifax.
Dr. F.R. MacKinnon	Department of Public Welfare, Halifax
Prof. John S. Morgan	School of Social Work, University of Pennsylvania
Mrs. D. Zarski	Canada Assistance Plan, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.

Invited - Could not Attend

Dr. C.A. Lanctot	Division of Social Medicine, University of Sherbrooke, Sherbrooke.
Dr. Boyd Suttie.	Division of Community Medicine, Faculty of Medicine, Memorial University, St. John's, Newfoundland.

Citizens Seminar

Dr. John Aldis	Medical Services Insurance Division, Ontario Department of Health 2195 Yonge St., Ontario.
Mr. John Barker	15 Steven St., Sault Ste. Marie
Ms. Novia Carter	Canadian Council on Social Development, Ottawa.
Dr. Anne Crichton	Research Co-ordinator, Community Health Centre Project
Mrs. Davie Fulton	SPARC, Vancouver.
Mlle. O. Gareau	Ministere des Affaires Sociales, Quebec
Miss P. Godfrey	Canadian Council on Social Development, Ottawa
Mr. J.E. Green	Department of Welfare, Charlottetown
Dr. Bruce Halliday	College of Family Physicians of Canada
Dr. James Haughton	Health & Hospitals Governing Commission of Cook County, Illinois.
Mr. J.A. MacKenzie	Department of Public Welfare, Halifax
Dr. Fred MacKinnon	Department of Public Welfare, Halifax
Dr. Peter New	Department of Behavioural Science, University of Toronto.
Mrs. D. Zarski	Canada Assistance Plan, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.

Architectural Seminar

Mr. John Allan	Assiniboine Clinic, Winnipeg
Dr. R.A. Armstrong	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. John Barker	15 Steven St., Sault Ste. Marie
Mr. A.P. Bergmann	Health Facilities Design Division, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. A. Bernholtz	Research Branch, Ministry of State for Urban Affairs, Ottawa.
Mr. J.A.L. Borsten	Albany Medical Clinic, Toronto.
Prof. Gilbert Blain	Department of Hospital Administration, University of Montreal, Montreal.
Prof. J.A. Buzacott	Department of Industrial Engineering, University of Toronto.
Mr. A.W. Cluff	Architect, Toronto.
Dr. W.J. Copeman	Health Services Branch, Ontario Department of Health, Queen's Park, Toronto.
Mr. J.F. Farrugia	Architect and Town Planner, Toronto
Mr. J.H. Fisher	Ogus & Fisher, Toronto.
Dr. W.H. Frost,	Indian & Northern Health Medical Services Branch, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mme. O. Gareau	Health Insurance & Diagnostic Services, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Mr. W.S. Goulding	Architect, Toronto
Dr. R.D. Guselle	Oshawa Clinic, Oshawa
Dr. W.S. Hacon	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Dr. J.C. Henderson	Applewood Clinic, Cooksville.
Mr. K. Izumi	Ministry of State for Urban Affairs, Ottawa.
Dr. P. Landry	Hochelaga-Maisonneuve, Montreal.
Dr. C. Lauriault	Maniwaki, Quebec.
Dr. B. Marien	Montreal
Mr. J. Markson	Architect, Toronto
Prof. D.L. Martin	School of Hospital Administration, University of Ottawa, Ottawa.

Dr. R. McAuley	Faculty of Medicine, McMaster University, Hamilton
Mr. J.A. McMillan	Peterborough Clinic, Peterborough
Sister M. McNamara	St. Michael's Hospital, Toronto
Mrs. B. Naylor	Saskatoon Community Clinic, Saskatoon
Mr. A. Nichol	Architect, Montreal
Mr. Z. Nowak	Architect, Ottawa
Mr. T.M. Ogrodnik	Health Facilities Design Division, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa
Mr. G.W. Peck	Health Facilities Design Division, Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
Docteur B. Rheault	Ministère des Affaires Sociales, Quebec.
Mr. D.M. Robertson	Crang & Boake, Toronto
Dr. J.W. Roche,	Ottawa.
Dr. R.W. Sutherland	School of Hospital Administration, University of Ottawa, Ottawa.
Prof. G.K. Palin	Department of Health Administration University of Toronto.
Dr. E. Tulchinsky	Department of Health & Social Development, Winnipeg
Mr. G.R. Wildblood	Oshawa Clinic, Oshawa

Finance Seminar

H.L. Laframboise	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
E.O. Landry	Department of National Health & Welfare, Brooke Claxton Bldg., Ottawa.
J.S.W. Aldis	Medical Services Insurance Division, Ontario Department of Health, 2195 Yonge St., Toronto.
L.F. Detwiller	University of British Columbia
E.E. Freamo	Canadian Medical Association
C. Faeder	Department of Health, Saskatchewan.
A.P. Ruderman	School of Hygiene, University of Toronto
D. Junk	Department of Health, New Brunswick
W.T.T. Davison	c.a., Windsor

B. Snell	University of Alberta Hospital, Edmonton.
J.Y. Rivard	University of Montreal
H. Mussalem	Canadian Nurses' Association
G. Simpson	Ministry of Health, Ontario
W. Leach	Ministry of Health, Ontario

Invited - Could not Attend

B. Brosseau	Canadian Hospital Association
R. Boileau	Ministere des Affaires Sociales, Quebec